Politics of Health Group

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Shadow Submission on the Right to the Highest Attainable Standard of Health in the UNITED KINGDOM

for the International Committee on Economic, Social and Cultural Rights

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by

The Politics of Health Group - UK
and
The People's Health Movement - UK

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The Politics of Health Group

The Politics of Health Group (PoHG) consists of people who believe that power exercised through politics and its impact on public policy is of fundamental importance for health. PoHG is a UK based group but with a clear international perspective and members throughout the world.

Our core principles
PoHG believes that:

- The opportunity for good health is the fundamental human right
- It is the responsibility of governments to strive for equitable social, economic and environmental conditions in which the health of all can thrive

PoHG's charter (see www.pohg.org.uk) sets out 16 principles that should guide political action and policy development for health. PoHG wants:

- The elimination of suffering caused by bad public policy
- To build better understanding of the political causes and consequences of health and ill health
- The promotion of health to be a central concern of politics so that public policy and social interventions focus on improving health
- Health services developed in accordance with the principles set out in the PoHG charter

The People's Health Movement

The People's Health Movement (PHM) is a movement of health activists and campaigners most of whom work at the grassroots in countries of the South. We share a common concern about deepening health inequalities and about the domestic and international policy directions that have a negative impact on health. We call for a renewal of the commitment to the principles and priorities of the Alma Ata declaration on Primary Health Care, and to the call for health for all.

Although a diverse and loose coalition, groups within the PHM share a common vision which is set out in the People's Charter for Health. The objectives of the PHM are:

- To promote the Health for All goal through an equitable, participatory and inter-sectoral movement and as a rights issue.
- To ensure universal access to quality health care, education and social services according to people's needs and not people's ability to pay.
- To promote the participation of people and people's organisations in the formulation, implementation and evaluation of all health and social policies and programmes.
- To promote health along with equity and sustainable development as top priorities in local, national and international policy-making.
- To hold accountable local authorities, national governments, international organisations and corporations.

The PHM is co-ordinated by a global secretariat, with circles at country and regional levels and circles for dialogue based around issues. Local, national and international campaigns bring the groups together. PHM UK is the local circle in the UK. We are health activists, campaigners, researchers and health workers who share the vision set out in the People's Charter for Health and who use this in our work in different ways. The UK circle is small. We link with the larger PHM Europe circle.

The production of this submission to the Committee on Economic, Social and Cultural Rights is an important focus of the work of the UK circle.

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Preamble

This civil society report on the right to the highest attainable standard of health in the United Kingdom (UK) has been coordinated by the Politics of Health Group (UK) and the People¹s Health Movement-UK.

The report is a response to the UK's Sixth Report under the International Covenant of Economic, Social and Cultural Rights. It draws upon the guidance provided by the Committee¹s General Comment 14 on the Right to the Highest Attainable Standard of Health, especially the affirmation that the enjoyment of those facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health must be accessible to everyone within the jurisdiction of the State party without discrimination.

We believe that the evidence we present here clearly demonstrates that the UK Government has committed violations of the Covenant through retrogressive legislation and policy, which is clearly inconsistent with conformity with the Covenant. These violations represent a common thread linking the three apparently disparate themes which we cover in this report.

Themes and authors

- ***Privatisation of health-relevant public goods and services*** - Alex Scott-Samuel (Subsection on *Corporate influence on public health policy* - Jeff Collin, Sarah Hill, Katherine Smith)
- ***Occupational and environmental health*** - Kathy Jenkins, Eurig Scandrett
- ***The right to positive mental health and wellbeing*** - Anuj Kapilashrami, Sumeet Jain, Iris Elliot

Section 1

Privatisation of health-relevant public goods and services

Recommendations

1. The UK government should modify the Health and Social Care Act 2012 in a way that does not restrict access to a comprehensive and geographically universal range of health care for the full population of England

2. The UK government should develop, and commit to, principles and guidelines which protect public health policy processes from negative influences of private sector actors that profit from commodities which are unhealthy when used (eg, tobacco) or when over-used (eg, alcohol and ultra-processed foods).

Reduced access to health care

During the period 2010-15 there has been a major deterioration in access to health care in England, which has also been associated with a deterioration in survival and with increased health inequalities. The primary causes of this have been the privatisation of the National Health Service (NHS) in England and substantial cuts in public services and welfare benefits. While healthcare is a devolved responsibility in each of the four UK nations, the welfare cuts have affected the public health throughout the UK.

The NHS in England

Prior to and following their election in May 2010, the parties comprising the Conservative - Liberal Democrat UK coalition government had stated that they had no intention of undertaking any major reorganisation of the NHS(1). Despite this, following its election the Government moved rapidly to draft the most extensive, radical reforms since the NHS was founded in 1948 (2,3). These reforms have introduced a widespread privatisation of the NHS (4, 5, 6). In addition, the Government's Health and Social Care Act 2012 (7) has led directly to the following changes, all of which have had the effect of reducing access to public sector health care, especially for the most disadvantaged members of the population (5). The changes include: the loss of the Secretary of State's responsibility to provide a National Health Service (8); the loss of a geographically universal health service; the

loss of the requirement to provide a comprehensive range of health services in each area; the fragmentation of what was in principle a seamless, integrated set of health services; and a move towards co-payments and user charges(2, 9, 10, 11). Although there is widespread published evidence supporting these conclusions, it has proved extremely difficult to discuss them in public, because the Government has always denied – and continues to deny – that these were its intentions or that these were the effects of its legislation(4, 12, 13).

The Health and Social Care Act 2012 (H&SCA)

The Health and Social Care Act 2012 (7) is a 473 page document thought to have been drafted by corporate and commercial lawyers (14). Its content and potential impact were described as follows during its passage - this description (5) has proved to be entirely accurate:
"...a commercial system in which the NHS is reduced to the role of government payer, equivalent to Medicare and Medicaid schemes in the US... In order to create a commercial market the government has repealed the health secretary's duty to provide or secure the provision of comprehensive care and has abolished the structures and mechanisms which follow from this duty. It has granted new powers and financial incentives to corporate commissioners and investors to redefine eligibility and entitlement for NHS funded care, select out profitable patients and services, and introduce regressive funding through patient charges and private healthcare: Investor-run commissioners and providers will be free to: invest in and form companies; use commercial contracts to bring in commercial providers; define the range of services to be provided and patient entitlements under the NHS; charge for some elements that are currently NHS services and for health services they determine are no longer covered by the NHS; generate and distribute surpluses to shareholders, investors, and employees by underspending the patient care budget; use competition law to challenge public policies that impair their profitability and freedom to operate; contract out all NHS services to a range of private providers; select patients and services; determine staff terms and conditions."

Privatisation and competition

The World Health Organization has defined privatisation in healthcare as "a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services"(15). From this perspective, it is clear that privatisation is both a central objective and a key outcome of H&SCA(4). Since the passage of H&SCA there have been many examples of how the quality and safety of

NHS clinical and supporting services have deteriorated(16, 17, 18) - sometimes with fatal results(19, 20). Despite this, there is evidence that Government pressure is resulting in substantial proportions of NHS services being transferred to private and 'third sector' providers. Between April 2013 and August 2014, only 30% of competitive tenders for NHS services and only 55% of all NHS contracts were awarded to NHS service providers(21). Although a further 25% of competitive tenders for NHS services and 10% of all NHS contracts were awarded to the voluntary and social enterprise sector, these once independent organisations have increasingly lost their autonomy and become dependent on Government funding(22).

A related objective is the opening of the NHS to international competition law. The passing of H&SCA has resulted in the introduction and rigorous enforcement of an international competition regime relating to the provision of a wide range of NHS services(10). While this is currently restricted to European competition law(23), the Government has stated its intention to include health services within the proposed Transatlantic Trade and Investment Partnership(24), so opening the NHS to the hazards of the US commercial healthcare market(25).

The financial context

The costs of creating a commercial market for NHS services are substantial. It has been estimated (26) that £1-3 billion was spent on establishing the NHS market and that maintaining it is costing between £4.5 billion (27) to £10 billion (26) annually. These are said to be conservative estimates(29). Given the total lack of evidence of any benefit to NHS users and the great costs in terms of poorer access, reduced quality and lost integration, it is unacceptable that these sums have been and are being wasted in this unproductive privatisation exercise.

Furthermore, there have at the same time been cuts in and rationing of NHS services in England on an enormous scale. Between the May 2010 general election and October 2014, 66 Accident and Emergency and Maternity units were closed or downgraded and 8649 beds were taken out of service(29). There have as a result been unprecedented rises in accident and emergency attendances(30). And while this was going on, the Department of Health was actually returning billions of 'underspent' funding to the Treasury in two successive years(31).

At the same time, there has been increasing Government pressure for doctors to ration the provision of services. This has not been explicit policy, but has chiefly occurred covertly, through new financial restrictions on general practitioner (GP) and

hospital budgets. As a result there is increasingly a 'postcode lottery' whereby it is easier to access certain services, eg community nursing, certain procedures, eg in vitro fertilisation, and certain operations, eg cataracts or joint replacements, in some areas than in others(32).

Towards an insurance based NHS

It is no coincidence that H&SCA, NHS cuts and 'underspends', and healthcare rationing in England have coincided in this way. There is published evidence that since the privatisations of many UK public services in the 1980s, Conservatives have made plans (2, 33, 34) for the conversion of the NHS into a health insurance based market, as in the US. The key architect of these proposals, who is now a senior Government minister, confirmed to a private meeting in 2004 (when he was an opposition MP) that these remained his clear intentions(35). And we know from an insider account of the introduction of H&SCA (36) that it was Mr Letwin rather than the Health Secretary Mr Lansley, who was 'in the driving seat'. One year after the Coalition took power, an adviser to the Prime Minister on the NHS told a private conference in New York that NHS reforms in the next two years would provide a "big opportunity" for the for-profit sector, and "would show no mercy" to the NHS - which would ultimately end up as "a financier of care similar to an insurance company rather than a provider of hospitals and staff"(37).

In addition to H&SCA, cuts and rationing, many further Coalition health policies can be seen as contributing to the same objective of a privatised, insurance based market. One example is personal health budgets(11), which featured in the original 1980s proposals as the basis for the intended national health insurance scheme(2, 33). Another is the covert sale of 15 years of NHS hospital records for every person in England to the insurance industry without any consultation(38). And yet another is the 'new models of care' recently introduced by NHS England chief executive Simon Stevens (previously of UnitedHealth). These models of care (39) are variants on a common theme of packaging healthcare into the equivalent of US health maintenance organisations and accountable care organisations(9) - systems whose many acknowledged deficiencies make them at best, poor substitutes for the single-payer public system they are proposed to replace.

The impact on the public health in England

Since 2012, life expectancy for men and women at all ages over 65 has for the first time stopped increasing in England, and has actually reduced in women aged 65 and over and in men aged 85 and over (40, 41). In some areas and age groups there have been statistically significant reductions for both sexes(40, 41). In 2008-10, after the credit crash but before the election of the Coalition Government, there had been no deterioration in elderly people's life expectancy(41). The director of public health who drew attention to these reductions stated "It is an unlikely, improbable and a frankly heroic assumption to assume that cuts such as these [in social care and meals for elderly people] will have no effect at all on frail elderly populations over 85 years old"(42).

Many suicides in England have been attributed to the harsh, often unjustified denial of money or help to welfare benefit claimants who fail to fulfil the demands of the Government's Department of Work and Pensions (43, 44). The Government has investigated benefit suicides but refuses to publish its report(43).

Another way in which Coalition Government policy has systematically damaged the public health in England is through the arbitrary alteration to regional and local NHS resource allocation formulas, to remove the weighting given according to local deprivation levels. It is of course well known that deprivation is associated with higher levels of ill health and therefore with higher service and resource requirements. By removing the deprivation weighting the Government has penalised the most needy areas - at a time when unprecedented cuts in local authority resources mean that social care is also being cut substantially(45). Cynics claim - accurately - that this change favours Government-supporting affluent areas at the expense of less supportive poorer areas. What is known is that deprivation-weighted NHS resource allocation is associated with reductions in health inequalities(46).

Corporate influence on public health policy

Non-communicable diseases (cardiovascular disease, cancer, respiratory disease and diabetes) are the largest cause of premature morbidity and mortality in the UK (47) and this disease burden is concentrated in less advantaged population groups (48). For the UK government to uphold the right to health, there is therefore a need for concerted actions to prevent, as well as treat, non-communicable diseases and for action to address the uneven distribution of the underlying risk factors - smoking, harmful drinking and obesity – which are more common in lower socioeconomic groups (47).

Recognition of the links between commercial interests, the consumption of tobacco, alcohol and unhealthy diets; and non-communicable diseases (49) has given rise to

the concept of ‘industrial epidemics’ (50). This concept, first applied to tobacco-related diseases, highlights the basic policy tension between public health objectives and the interests of multiple business sectors (50).

UK governments have recognised this tension for tobacco, including by ratifying the first international health treaty initiated by the WHO, the Framework Convention on Tobacco Control (FCTC) (51), which includes a commitment to protecting public health policy from tobacco industry interference. But successive governments have taken a starkly different approach to the alcohol and processed food industries. Rather than effectively regulating their activities, the current UK government has positioned food and alcohol companies as policy ‘partners’, providing them with a privileged status in national health policy initiatives, notably via a ‘Public Health Responsibility Deal’ in which businesses voluntarily sign up to various health-related ‘pledges’ (52). The voluntary nature of these pledges, and their focus on downstream, superficial interventions which are known to be both less effective than more upstream, fundamental alternatives and more likely to increase health inequalities (53), enable industries profiting from commodities that are harmful to health to shape the regulatory environments in which they are operating (54).

There is extensive evidence demonstrating how tobacco, alcohol and processed food industries seek to divert policy attention away from measures most likely to protect public health when such measures would negatively impact on profits (55, 56, 57). For example, evidence demonstrates that the UK alcohol industry has promoted educational campaigns, known to be ineffectual (58), while pressuring policymakers to abandon more effective measures for reducing alcohol-related harm (59). Concerns about the alcohol industry’s ability to limit protective public health policies via its involvement in the Public Health Responsibility Deal for alcohol led to health advocates withdrawing (60).

All of this suggests that the UK government is prioritising business interests over those of public health and in so doing, failing to adequately protect the UK population’s right to health. Given the unequal distribution of non-communicable diseases, this failure is most profound for people in lower socio-economic groups.

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Section 2

Occupational and Environmental Health

Recommendations

Regulation and enforcement should be at the centre of the protection of occupational and environmental health. The UK government and devolved administrations should:

1. Protect and strengthen Health and Safety enforcement and Environmental Health enforcement;
2. Reject the deregulation argument and where necessary strengthen Health and Safety and Environmental Health regulation;
3. Ensure that Regulation is made effective by full participation in decision making by those most affected. This involves stronger rights to access information, proactive participation and right of appeal for communities and environmental NGOs, and stronger trade union rights including the right to refuse unsafe work.
4. Make Environmental and Health impact assessments of real value to those affected most by proposed changes by full proactive involvement of users, communities, NGOs, trade unions
5. Provide substantially improved resourcing and methods for research and monitoring in the fields of OH&S and Environmental Health. As part of this, develop innovative methods of workplace and community participation to harness local skills and knowledge.
6. Develop a comprehensive Occupational Health Service as an integral part of the NHS
7. Orientate public health promotion activity towards tackling the real causes of environmental and occupational illness – the corporations and managers that shift the costs of their activities onto the workforce and the wider community.
8. Adopt a statutory Toxics Use Reduction Strategy.

Summary

In this section we will discuss the impact of poor working conditions and corporate practices, allowed through inadequate regulation and enforcement, on the health of working people and retired workers, their families and communities. We will look at the major contribution that work related injury and ill health make to inequalities in health in Scotland, as well as the impact of environmental injustice to directly affected communities. We will make the connections between occupational and environmental exposure to dangerous substances and hazardous processes and

relate them to their common causes in corporate neglect, unaccountability and financial decision making. We will detail evidence of the need for and effectiveness of enforcement action and reductions in resourcing and political support for enforcement activity. We will outline deficits in the provision of occupational health services in Scotland and make proposals for their improvement. We will query whether these failures in O/EH&S regulation and service provision contradict UK commitments at European and international levels.

Occupational and Environmental Health

The environmental causes of ill health experienced at work and in communities that are the result corporate practices of private or public bodies and the failure of the state to regulate are a significant if poorly measured contribution to morbidity and mortality of the population. Moreover, commitment to economic growth and the implementation of measures designed to increase productivity and competitiveness in public services as well as private enterprise provides a disincentive to governments to acknowledge or assess the problem, let alone regulate and avoid it. The current drive for deregulation, privatisation and the removal of what has been erroneously described as 'red tape' barriers to business growth, is exacerbating the situation. As a result, it is estimated that millions of people in the UK suffer from preventable illnesses caused through the environment in which they live and work. The impact on health from occupational and environmental factors is not experienced evenly throughout the population and is a significant contributor to inequalities in health. There is good evidence that people experiencing poverty, social exclusion and in low paid, insecure work, are more likely to be exposed to occupational and environmental causes of ill health. Evidence gathered by the WHO reports:

> *"A number of employment-related conditions are associated with poorer health status, including unemployment and precarious work – such as informal work, temporary work, contract work, child labour, and slavery/bonded labour. Evidence indicates that mortality is significantly higher among temporary workers compared to permanent workers (Kivimäki et al., 2003). Poor mental health outcomes are associated with precarious employment (e.g. informal work, non-fixed term temporary contracts, and part-time work) (Artazcoz et al., 2005; Kim et al., 2006). Workers who perceive work insecurity experience significant adverse effects on their physical and mental health (Ferrie et al., 2002). The conditions of work also affect health and health equity. Poor work quality may affect mental health almost as much as loss of work (Bartley, 2005; Muntaner et al., 1995; Strazdins et al., 2007). Adverse conditions that expose individuals to a range of health hazards tend to cluster in lower-status occupations. Work-related fatalities through*

> *hazardous exposures remain an extremely serious problem (ILO, 2005) (Fig. 7.1). Stress at work is associated with a 50% excess risk of coronary heart disease (Marmot, 2004; Kivimäki et al., 2006), and there is consistent evidence that high job demand, low control, and effort-reward imbalance are risk factors for mental and physical health problems (Stansfeld & Candy, 2006)."* (1)

Where causes of ill health are often diffuse, historical and unknown, and there is a vested economic interest in obfuscation, the identification and measurement of such factors is problematic. Despite the difficulties in accessing prevalence data, research conducted by small groups of scholars and some NGOs has exposed the widespread extent of occupational and environmental ill health.

It has been estimated that around 20 per cent of deaths from heart disease, cancer and chronic respiratory disease are caused or related to work. The prevalence of many forms of cancer are increasing in the population in correlation with the use of known carcinogenic chemicals, such as endocrine disruptors, dioxins and furans, as well as other synthetic chemicals which are untested either singly or in combination. Official statistics put the number of deaths from work related illness at 12,000 per year in the UK, which is certainly a gross underestimate (2) If the 20% estimate, based on increasing research evidence, is closer to the truth, this would put annual work-related disease deaths closer to 50,000 (3) Work related ill health is likely to be in the millions.

In Scotland, the situation is particularly severe, but what Watterson and O'Neill say of Scotland can largely be applied throughout the UK.

> Scotland has one the highest rates of workplace sickness absence in the UK, and work-related ill-health and injuries are responsible for about a quarter of this. It is a sizeable and particularly preventable slice of the total sick leave toll. The contribution of poor environmental standards is poorly quantified, but is certainly real and certainly substantial. This is not a cost borne equally across Scottish society. A much greater burden, witnessed by greatly increased mortality and morbidity, is seen the lower you travel down the socioeconomic scale. Poverty, a poor living and working environment and job insecurity are substantial contributory factors to this health inequity. It concentrates risks in sections of the community, many of which are easily identified and could be easily targeted for preventive action. However, strategies to address health inequalities in Scotland bypass occupational and environmental health and perpetuate this disadvantage. (3, page 1)

Environmental causes of ill health outwith the workplace are even more difficult to assess. Many environmentally mediated public health issues, including housing, sanitation and food, have been a concern for over a century, yet continue to affect the poorest sections of British society and are exacerbated by recent austerity policies. However, in recent decades, to these have been added an increasing

cocktail of largely untested and frequently toxic synthetic chemicals. The International Agency for Research on Cancer estimate 7 to 19 per cent of all cancers worldwide are due to toxic environmental exposures (4) A recent report from the World Health Organisation (5) suggests that a number of diseases of children, adolescents and adults have their origin in the impact of endocrine disrupting chemicals on the developing foetus. Whilst many endocrine disruptors (PCBs, dioxins, furans, DDT) have been withdrawn from use, these highly persistent chemicals can still be detected in the environment and in human and wildlife samples and may be released into the environment through waste management processes. Other known endocrine disruptors continue to be introduced in industrial and agrochemical processes and in consumer products, including perfluorinated chemicals, phthalates and bisphenol A. In some cases, partial restrictions are in place to protect the most vulnerable, but the use of and therefore expose of workers and the public to these chemicals continues to increase.

Opportunities for citizens and public interest organisations to challenge the development of environmentally hazardous developments are limited. Land use planning systems in Scotland and in England and Wales have a presumption in favour of development, and the right to appeal decisions is denied to those most affected (third parties) whilst provided to developers. The UK and its devolved administrations have been found to have failed their obligations under the Convention on Access to Information, Public Participation in Decision-Making and Access to Justice in Environmental Matters (Aarhus Convention), largely by constructing financial barriers and failing to ensure that the costs involved in accessing mechanisms of justice are not prohibitively expensive. (6)

The default position in terms of regulation is to allow industry to innovate and introduce new chemicals with minimal testing, and only subsequently restricting or withdrawing their use once harm has been significantly detected, and only then with considerable reluctance. Indeed, UK regulations typically incorporate a built in presumption in favour of industrial development and therefore against the protection of workers and the public from health risk. The Health and Safety at Work Act 1974 requires the protection of the health and safety of workers ‘so far as is reasonably practicable’, whilst the British approach to integrated pollution control privileges economic imperatives over health and environmental risks through ‘Best Available Technology Not Entailing Excessive Costs’. This UK approach in relation to workplace H&S is at odds with much of Europe and some argue is against EU regulation.

Meanwhile, health promotion activities and approaches to tackling social determinants of health have increasingly been driven by an individualising and ‘lifestyle’ approach, which leaves the structural causes unchallenged. This has been a deliberate policy of UK government in line with its approach to putting the interests of business growth above the interests of public health. As the Alliance for Cancer Prevention has put it, public health efforts

> “target ‘lifestyle’ factors when we should be targeting ‘life circumstance’ factors. There is no consideration given to the ‘confounding risk factors’

namely environmental and occupational exposures to harmful chemicals, substances and practices in our homes, workplaces and in our wider environment."

On the other hand the UK has some of the worst Occupational Health Service provision in Europe. Only 1/3rd of working people in Scotland have access to any occupational health service and only 3% to a fully comprehensive service. (7) It is welcome that the Scottish Government has taken steps beyond what is done in other parts of the UK, including the establishment of the Scottish Centre for Healthy Working Lives and Working Health Services Scotland, but provision is still poor and unacceptable. This is particularly so in light of strong evidence from WHO that OH Services contribute toward sustainable development, environmental protection and the overall protection of the working population from work-related ill-health, injuries and accidents at work. WHO states that all workers should have access to occupational health services. (8) (9) (10).

Within European law, The Framework Directive (89/391) requires that all workplaces should have preventive occupational health services. This in turn is based on the International Labour Organisation Convention 161. The UK has yet to ratify this convention which requires ratifying countries to formulate and implement a coherent national policy on OH services, and to progressively develop OH services for all workers. Many would also argue that the UK has also failed to comply with the European Framework Directive requirements on occupational health. The HSE has brought a prosecution (Dundee Council 2006) because it did not provide access to OH services. This prosecution was based on regulation 5 of the Management Regulations which says that 'employers should make arrangements to manage effectively health and safety' (11)

Air pollution in the UK continues to be a significant preventable environmental cause of ill health. (12) In 2013, the WHO's International Agency for Research on Cancer suggested that the carcinogenic cocktail of chemicals in air pollution is a leading cause of cancer deaths in all regions of the world. Particulate matter in air pollution is also a major source of ill health, with DEFRA reporting 29,000 deaths in the UK resulting from anthropogenic airborne particulate matter. (13) This report also suggests air pollution is responsible for an overall average reduction in life expectance of 6 months, although this average will inevitably conceal a considerable inequality in exposure. Airborne particulate matter has also been associated with cardiovascular mortality. (14) In November 2014, in a case brought by the environmental NGO Client Earth, the European Court of Justice ruled against the UK and demanded that the government and devolved administrations set urgent action plans to reduce air pollution in a number of its major cities. (15)

Regulation of occupational and environmental health in the UK is divided between the Health and Safety Executive (a reserved body governed by Westminster) and devolved environmental protection agencies (Scottish Environment Protection Agency, Environment Agency in England and Wales), local authority environmental

health departments and NHS public health. Recent proposals to the Smith Commission to devolve the responsibilities of the HSE were not accepted. Neither have they been totally rejected, leaving a frustrating ongoing discussion without a clear structure or endpoint.

The UK government has recently embarked on a major ideologically driven programme of deregulation of health and environmental protection, including severe cuts to funding of responsible agencies, restrictions in the inspection regimes, populist measures such as the 'red tape challenge', a cultural-ideological offensive against mythical 'health and safety culture' and 'compensation culture' and the commercialisation of functions of the regulatory bodies. Budgets and staffing levels in the HSE and Environment Agency have been severely cut and SEPA has largely followed suit – between 2012 and 2015 the HSE experienced a funding cut of 35 %. Local authorities have also been instructed to cut environmental health inspections by one third. Together these changes have led to diminished regulation and a resultant impact on health. In 2010/1, only 1 in 65 of all fatal and major injuries recorded by HSE resulted in any enforcement action and fewer than one in 170 resulted in prosecution. (16) In 2011, the Department for Work and Pensions announced reforms to the agency's operation, including ceasing proactive inspection except in a small number of 'high risk' industrial sectors eg offshore oil, construction, coal mining, leaving most enterprises exempt from proactive inspections and increasingly immune from regulation. This includes sectors which are clearly not 'low risk', eg agriculture, docks, schools, hospitals, electricity, prisons, quarries... Prospect union, which organises HSE employees, has estimated a reduction by 90% of occupational health inspections as a result of HSE cuts and deregulation. (17) The introduction of cost recovery mechanisms also paved the way for the current drive to commercialise the operations of the HSE. Voluntary schemes are preferred, despite ample evidence of failure of such schemes as the directors' leadership guidance; the Corporate Health and Safety Performance Index; and the Asbestos Building Inspectors Certification Scheme. (18) On the other hand, schemes involving trade union Worker Safety Advisors which had a significant success rate have been discontinued. (19)

This is all in the face of strong evidence on the effectiveness of enforcement. An academic review of the international literature carried out by Dr Courtney Davis in 2004 found that "*the evidence shows, overwhelmingly, that it is regulation – including the threat of credible enforcement – which is the primary driver motivating organisations to improve their OH&S performance".* (20) This finding is reiterated by the Work and Pensions Select Committee report on the work of the HSC and HSE (2004) recommended that:

> *15. The evidence supports the view that it is inspection, backed by enforcement, that is most effective in motivating duty holders to comply with their responsibilities under health and safety law. We therefore recommend that the HSE should not proceed with the proposal to shift resources from inspection and enforcement to fund an increase in education, information and advice.* (21)

It is clear that in its ideologically driven commitment to 'freeing' business from as much regulation as possible, the current government is privileging the economic interests of investors and putting at risk the health of millions of people in the UK, and that the poorest and most vulnerable will be disproportionately impacted. This is a deliberate policy of distributing wealth to the most wealthy at the cost of the lives of the poorest. Moreover, this is occurring in the context of widespread austerity policies, significant shifts away from the public to the private sector, reductions in public services, encouragement of the practices of work casualisation, and ideological privatisation of responsibility and scapegoating of the most vulnerable. In this context, exposure to insecurity and occupational and environmental risks is reaching an ever larger section of the population who are either in poverty, or at risk of poverty. Whilst the November 2014 European Court of Justice verdict on air pollution demonstrates that the government is not entirely immune from accountability, nonetheless it has largely escaped taking responsibility for its onslaught on the population through impacts of its policies on occupational and environmental health.

> "A failure of governments to address health inequalities in occupational and environmental health means related risks are concentrated in certain sections of the population. Deaths related to hazards in the workplace and the wider environment are not a feature of the boardroom, they are just the consequence of decisions made there. A dramatic rise in job insecurity, marked by increases in unemployment, underemployment, enforced part-time time and temporary working, is making a bad situation worse and is a problem exacerbated by the progressive erosion of employment and welfare rights." (3, page 4)

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Section 3

The right to positive mental health and wellbeing

Recommendations

The UK Government must correct the underlying determinants of poor mental health and rebalance the funding inequality. The recommendations draw on multiple sources - findings of the participatory action research on health inequalities and Scottish health manifesto by Peoples Health Movement, and other useful resource including the Mental Health Foundation manifesto and the secret manifesto by Royal College of Psychiatrists. Specifically, we demand:

1. **Greater investment in public mental health** and preventive efforts to prioritise 'upstream' investment. Specifically, commitment to and investment in the development of Health in All Policies to address the social determinants of public mental health
2. **Integration of primary and secondary care** to provide a continuum of care, and bridge the gap between physical and mental health (by improving mental health of those with physical health problems and conversely improving physical health of those with mental health problems).
3. **Rebalance the funding inequality** to ensure spending reflects the growing need and demand, and address culturally-specific mental health needs of different communities through tailored services. Commit to real terms increases in funding for mental health services for both adults and children in each year of the next Parliament. Ensure no further cuts to mental health programmes/ services are implemented and the healthcare and welfare budgets reflect the needs of this vulnerable group.
4. **Address specific vulnerabilities of multiply disadvantaged and stigmatised groups such as minority ethnic groups, women and children.** Implement early detection and intervention to protect and promote well-being, for example, women's access to mental health support during and after pregnancy, raising children's awareness of mental health and well being by putting it on the national curriculum and training teachers and school nurses, and investing in parenting programmes across the UK.
5. **Combat stigma** and improve the lives of people with mental health problems. Core fund anti stigma campaigns across the UK, including Time to Change in England and Wales, See Me in Scotland and a campaign in Northern Ireland (the only part of the UK without a regional anti-stigma campaign). Offer integrated health and employment support to people with mental health conditions who are out of work.
6. **Improve availability and access to quality mental health services.** Introduce and monitor maximum waiting times for mental health care and

support, including psychological therapies. Commit to i) continued improvements in mental health crisis care, including liaison psychiatry services in all hospitals; ii) a holistic approach to early detection and intervention to support young people, their physical health, education or employment, social skills and family relationships. Continue to fund liaison and diversion mental health services, working with police and the courts.

7. E**nsure active labour policies and reliable social protection measures** (for example, the Scandinavian welfare regime) as they have shown to have beneficial effects on the health and well-being of older workers (Dragano N. et al. 2010).

8. **Ensure safeguards for people with mental health conditions in custody of the State.** Improve the availability and access of tailored mental health services to ensure that detention occurs on when absolutely necessary and in the 'least restrictive conditions'. To prevent violation of the human rights of detainees with mental health conditions, implement staff training for medical and police officials (and staff of detention facilities) on the relevant provision of the Mental Health Act and for timely referral of vulnerable detainees to health care professionals. Also ensure maintenance and monitoring of records of any force used to restrain persons with mental health conditions.

Background & Status of mental health

Inequalities and Burden of mental health and well being

Mental health is a fundamental prerequisite for health and development; both a determinant and a consequence of a wide range of social and health outcomes at individual, community and societal levels. Mental ill health is the single largest cause of ill-health and diasability in the UK, accountting for 23% of the total burden of disease. Poor mental health contributes to socio-economic and health problems such as higher levels of physical morbidity and mortality, lower levels of educational attainment, poorer productivity, greater incidence of addictions, higher crime rates and poor community and societal cohesion (McCulloch & Goldie, 2010). These result in high social, human and economic burden, and significant costs to the health system. The economic and social cost of poor mental health in England alone is estimated at £105.2 billion annually (European Social Charter, Government of UK 2013).

Mental health cannot be seen in isolation. Persons with psychological disabilities experience significantly poorer physical health conditions, including much shorter life expectancy than those without mental health problems. Within the United Kingdom, one third or 33,000 out of 100,000 'avoidable deaths' that occur every year are in people with mental health problems. Compared with the general population, people with serious mental illness experience twice the risk of diabetes, 2-3 times the risk of hypertension, 3 times the risk of dying from coronary heart disease, a 10-fold increase in deaths from respiratory disease for people with schizophrenia, and 4.1

times the overall risk of dying prematurely (than the general population aged under 50). These figures are a reflection of one of the starkest health inequalities in our society. Despite evidence that people with serious mental illness are at risk of dying, on average, up to 20 years prematurely (Mental Health Policy Group England 'A Manifesto for better mental health - General Election 2015), we are not proactively seeking to close this gap.

Likewise, 30 percent of people with long-term physical health condition (approx. 4 million people in England) experience mental health problems, most notably depression and anxiety, or dementia in the case of older people (Naylor et al. 2012). Many of them experience significantly poorer health outcomes and reduced quality of life as a result. By interacting with and exacerbating physical illness, co-morbid mental health problems are reported to raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. One estimate suggests that poor mental health and well-being costs the NHS between £8 billion and £13 billion in England each year (or 12-18 per cent of NHS spending on long-term conditions) (Naylor et al. 2012).

There are gross inequalities in the distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health. This results in an unequal distribution across population groups of mental health problems and illness and in people's ability to recover and lead fulfilling lives (Goldie et al. 2013). People with mental health problems often have fewer qualifications (Chevalier and Feinstein 2006), find it harder to both obtain and stay in work (Meltzer et al. 2010), have lower incomes (Mcmanus et al. 2009), are more likely to be homeless (Rees 2009) or insecurely housed, and are more likely to live in areas of high social deprivation (Cooper 2008). The relationship between growing up in a low-income household to poor mental health is well established (Costello *et al.*, 2001; DCSF, 2007; Fabian Society, 2006; HM Treasury, 2008). Childhood poverty has been associated with low psychological and intellectual development (Aber *et al.*, 1997 in Griggs and Walker 2008).

People with long-term physical health conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources (Naylor et al 2012), albeit mental health contributes a significant burden in other marginalised and socially excluded populations such as black and minority ethnic communities and young people (Lankelly Chase Foundation 2014).

The UK has ratified Human Rights instruments but not put in place robust implementation systems for action with equitable impact across England and the devolved administrations. These deficiencies and violations are presented in the following section.

II. Policy and Implementation barriers to realise the right to positive mental health
Austerity and systemic/ structural determinants and the context of disenfranchisement: A strong correlation between inequalities in wealth and

psychological distress has been shown in the UK & Europe (Carter KN et al. 2009). According to a research report by Samaritans, those in the poorest communities are ten times more likely to commit suicide than the affluent. Likewise, the Scottish health survey (2012, 2013) confirms that poor mental health and wellbeing is most strongly associated with economic activity, most pronounced for the group of adults who are permanently unable to work. In particular, population mental health in the UK has deteriorated following the onset of the recession, and aggressive roll-out of austerity measures; and it is argued that this association does not appear to be limited to those out of employment nor those whose household income has declined (Katikireddi et al. 2012), albeit the effects are pronounced.

Austerity is at its core a class issue, privileging the right of the wealthy over the right of poorer communities to a basic standard of mental healthcare. Austerity has undermined mental health in significant ways: First, loss of livelihood/ reduced employment opportunities, declining income, growing insecurity and deteriorating conditions at workplace have resulted in an ever increasing demand for mental health support services. It is estimated that by 2030 there will be approximately two million more adults in the UK with mental health problems than there are today. (Mental Health Policy Group England 'A Manifesto for better mental health – General Election 2015). Second, despite a stated government commitment to parity, investments in mental health is failing: in early 2014 NHS England and Monitor mandated a 20% greater cut to mental health and community services budget than their acute counterparts (Mind 2014). Funding for mental health services has been cut in real terms for three years in a row. These cuts to mental health care mean fewer people have access to early intervention treatment, such as talking therapy, and more cases of psychosis and schizophrenia end up in hospitals rather than being supported in the community. The report *Investing in Recovery* (by Rethink Mental illness and the London School of Economics) estimates that hospitalisation costs the NHS £350 daily as compared to an average of £13 if supported in the community; arguing that a shift in the approach (towards community services) will save the NHS £50 million a year. Even in hospitals there is acute shortage of beds. The LSE estimates 30,000 people with mental health conditions have lost their social care, while 1,700 beds have been cut in England. Over a fifth of doctors said they had sent a child over 200 miles away from their families for treatment, and a similar number admitted sectioning people just to get them a bed. There are huge regional disparities too, as Birmingham City Council reduced its budget for adult mental health by an incredible 94 per cent. Likewise, Camden and Islington Foundation Trust reduced more than 100 beds between 2011 and 2014 (approx. 19.1 percent) and witnessed the largest reduction in nursing staff (18 percent). Despite the existence of cost-effective treatments mental health receives only 13% of NHS health expenditure. Reports have revealed that huge proportions of people with mental health problems get no treatment at all (only a third of people with

depression) and even fewer get the right treatment. Third, austerity has led to a meltdown of prevention efforts. Half of early intervention programmes targeted at young people have been cut. 54% of the budget for psychotic illness is spent on inpatient care rather than on preventive community services. There is strong evidence in favour of recovery-focused services, especially early detection services and early intervention teams, crisis resolution and home treatment, family therapy, cognitive behavioural therapy, and peer support; and their potential to contribute to recovery outcomes, reduced costs of hospital admissions, and/or better value for money (Knapp et al. 2014). Yet, progress on this front has been limited.

While mental health services are in meltdown there are disturbing trends in mental health problems, and a 13 percent increase in the number of people being referred to community mental health services was recorded in 2013. Suicide rates offer one stark example of this trend. Latest figures published by Office of National Statistics reveal a four percent rise in the number of suicides in the UK in 2013, with nearly 78 percent affecting men, the highest since 2001. There are significant regional, age- and sex-based variations in suicide rates; the highest for females and for all persons was reported in Scotland and for males (24.0 per 100,000) in Northern Ireland; the lowest were found in England. Yet research and policy debate is disproportionately focused on examining the social and economic implications of mental health in England.

Policy barriers: UK policy approach to mental health has been fragmented. This can be attributed to the "institutional and professional separation of mental and physical health care" (Naylor et al. 2012), which undermines improvements in quality and efficiency; and poor links between mental health professionals and primary care, the first point of care and support for people with mental health problems. Increasing sub-specialisation and the decline of generalism in hospital settings creates a lack of co-ordination and oversight of patients' multiple needs (Finlay et al 2011). Current estimates suggest gross deficiencies in meeting the needs of the population affected by mental health problems; just 25 per cent of adults with depression and anxiety get any treatment and only 65 per cent of people with psychotic disorder.

There are a number of policy-level factors that restrict access to the right to positive mental health. In recent years, mental health policies in England and Scotland have sought to increase access to psychological therapies. Most significantly, the UK government, in a 2014 strategy *No Health Without Mental Health* and *Closing the Gap,* sets out targets for timely access to services and for treatment, the most obvious gaps in parity. It commits and £80 million investment to deliver: "treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks".
However, progress in meeting targets to reduce waiting times for such services has been poor. Recent Scottish government figures indicate that in the period ending December 2014, 15.5% of patients waited between 19 and 35 weeks and 4.4% waited 35 weeks to be seen. For children and adolescents, 78.9% were seen within

18 weeks. Whilst incremental progress is being made, grassroots experiential accounts of access appear in stark contrast. During the Participatory Action Research undertaken in Scotland (mainly Edinburgh, Glasgow and Aberdeenshire), parents who were primary carers for their children experienced ruptures in care during the transition from child to adult services, reported delays of a year or more between their appointments, which were compounded by poor postal communication. It is therefore recommended that the mental health plan be implemented in full force under the new government and adequate measures be put in place to monitor mental health access and waiting times across all administrations in the UK.

Furthermore, Mental health policies in England and Scotland have privileged therapeutic interventions that are claimed to be low cost and based on a strong empirical evidence base, such as cognitive behavioural therapy (Timimi, 2014) over integrated and alternative approaches to care. Programmes such as 'Increasing access to psychological therapies' limit the range of available interventions, and reduce choice. This limits funding and development of alternative approaches for marginalized populations, such as intercultural psychotherapy (Kareem & Littlewood, 2000).

Cracks in the system of care; systemic violations: Inadequacies in the care system have resulted in gross violations, notably the rising incidences of suicides in detention. A recent enquiry by the Equality & Rights Commission (2015) reports gross failure in protecting the human rights of detainees with mental health conditions across a range of institutions: health, prison and police settings in England. The care system is characterised by a range of failures including i) poor monitoring and observation of patients and prisoners at serious risk of suicide; ii) lack of appropriate follow-up mental health support put in place, including involving families in supporting detainees; iii) combat widespread bullying, threats and intimidating behaviour towards inmates; iv) gross violations of the rights of people affected by mental health including inappropriate detention in police custody and violent use of restraint and tasers. In addition the enquiry also reveals the absence of any independent investigation/redress mechanisms or independent body that could investigate deaths of people with mental health conditions in hospitals. When the state detains people for their own good or the safety of others it has a very high level of responsibility to ensure their life is protected. For people with mental health conditions that is a particular challenge with a large number of tragic cases over the past few years where that responsibility has not been met.

Stigma: High levels of prejudice and discrimination against people with mental health problems and those using mental health services has been reported; and contributes to damaging outcomes as well as perpetuating self-stigmatisation and contributing to low self-esteem (Mehta et al. 2009; Thornicroft 2006). The general election 2015 manifesto by the Mental Health Policy Group reports that stigma and discrimination affect 9 out of 10 people with mental health problems, restricting people's working lives, curtailing their social lives and relationships and leading to social isolation; and

at its worst, leads them to give up on life. A series of anti-stigma campaigns have been launched in England and Scotland, with varied progress. Campaigns such as 'See Me' and 'Time to Change', have been supported by the UK Department of Health and the Scottish government along with organizations such as Mind, Comic Relief and the Big Lottery Fund. A study and subsequent report in 2014 conducted by TNS (Taylor Nelson Sofres) and the Institute of Psychiatry, Kings College London shows that since the second phase of Time to Change's campaign (2011), two million people have improved attitudes towards people with mental illnesses and 2012-2013 showed the biggest annual shift in the last decade regarding people's improved attitudes towards people suffering with mental health issues (Evans-Lacko et al. 2014).

Programmes such as these have delivered tangible improvements, but as evident from the figures above, significant work remains to be done. The programmes mentioned above are dependent on government funding, and this funding is currently at risk in light of the current government's austerity policies. It is therefore recommended that Anti- Stigma campaigns continue to receive funds from the UK

Mental Health Legislation: A number of concerns have been raised about the use of mental health legislation to detain people and provide compulsory treatment. Mental health legislation in England has been criticized by mental health groups and the Health Select Committee of the House of Commons (2013). A central issue relates to rising numbers of people being detained under the Mental Health Act and subject to 'community treatment orders' (Health & Social care information Centre, England 2013/14). Between 2011/12 and 2012/13 there was a 6% rise in the number of people detained in England under the Mental Health Act in hospital or under a community treatment order. Since 2010, the number of detentions in hospital has increased by 9%, the increase not attributable to population growth (Care Quality Commission, 2015). The number of children being detained is also high; in 2012, 300 under 18s were detained under the Mental Health Act in England, and 305 were held during the first 11 months of 2013 (http://www.bbc.co.uk/news/uk-25900085). Both the Health Select committee and the Care Quality Commission have expressed concern that bed shortages may be forcing mental health professionals to detain patients in order to secure a bed. The Health Committee queried whether increase in detentions might be linked to the controversial introduction of an 'appropriate treatment test' in the mental health act 2007. This test has widened the range of available treatment for which a person might be detained. The Health Committee also raised concerns about 'de-facto detention' -where voluntary patients are threatened with detention if they leave the ward.

The Care Quality Commission (2015) found that in a quarter of patient records reviewed, there was no evidence of a patient consenting to treatment. Additionally, the Commission received evidence from patients that in many cases they were not involved in decisions about their own treatment.

The right to independent mental health advocacy is enshrined in the 2007 Mental Health Act. The Mental Health Alliance (2012) found that advocacy services in England have not received adequate funding, are overstretched, and health staff are often not aware of patients' rights to advocacy. Similar concerns have been raised in Scotland around provision of adequate resources for advocacy services.

A more fundamental challenge is the incompatibility of mental health legislation with the UN Convention on the Rights of People with Disabilities (UNCRPD). The Convention states (Article 14, paragraph 1b) that having a disability should not be used to justify deprivation of liberty. The Office of the UN High Commissioner for Human Rights interprets compulsory detention of people with a mental disability for care or treatment as discriminatory because they are based on an individual's disability (Szmukler et al., 2013). The Essex Autonomy project has found that current mental health legislation in the UK does not comply with the UN Convention on the Rights of Persons with Disabilities ratified by the UK in 2009. In particular, The Essex project argues that definitions of mental incapacity under the Mental Capacity Act of England and Wales unfairly discriminates against people with psycho-social disabilities because they define this mental incapacity as being restricted to "an impairment of, or a disturbance in the functioning of, the mind or brain". They recommend the removal of any reference that defines mental incapacity in this way so as to achieve compliance with Article 5 of the UNCRPD (Martin et al., 2015).

Equity (needs of disadvantaged groups) - factors underpinning poor mental health and access to comprehensive services are unequally distributed in the society. Vulnerabilities are enhanced on the basis of ethnicity, gender, sexual identity, disability, income levels and age.

Certain ethnic groups in the UK are likely to have higher rates of admission and detention in mental health facilities, higher rates of diagnosis, and are more likely to have poor treatment outcomes and to disengage from services. Recent Scottish research (Bansal et al., 2014) indicates that certain ethnic minority groups are at greater risk of detention in mental health facilities. People reporting as being from a mixed ethnic groups and of African or Chinese origin were at higher risk of detention, particularly long-term detention compared to those from a White Scottish background. For example, detention rates under the Mental Health Act during 2012/13 were 2.2 times higher for black African, 4.2 times higher for black Caribbean and 6.6 times higher for black other ethnic groups than the national average (Care Quality Commission (2014). These inequalities in England and Scotland have been linked to a number of factors including racism (in society and the mental health system), cultural inaccessibility of the mental health system and different patterns of help-seeking amongst some minority groups. Policy efforts such as the 'Delivering Race Equality' (DRE) programme in England have sought to address these inequalities. However, an evaluation of the DRE found that the programme struggled in the face of institutional racism within the NHS, marginalization of its initiatives in NHS structures, and a lack of sustainability (Craig and Walker, 2012).

Gender inequalities in mental health are even more pronounced. It is noted that women are up to 40 percent more likely than men to develop mental health conditions in the UK women are more likely to have reported and been treated for a mental health problem than men (Freeman, D. in The Guardian 2013). These vulnerabilities are enhanced for pregnant women and new mothers. Up to 20% of women (more than 1 in 10) develop a mental illness during pregnancy or within the first year of giving birth. These not only impact adversely on the mother but also have been shown to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences (Bauer et al. 2014). However, almost half of the pregnant women and new mothers in the UK do not have access to specialist perinatal mental health services, potentially leaving them and their babies at risk (ibid). Suicide is one of the leading causes of death for women during pregnancy and the first year after birth (Bauer et al 2014).

Children and young people in the UK have high levels of emotional and mental distress. One in ten children have a mental health problem and one in twelve children and young people deliberately self-harm. A coalition of British NGOs, the Children and Young People's Mental Health Coalition reports a 68% increase in admissions of young people for self-harm (Mental health Foundation 2006). With cuts in services described above, children and young people are a vulnerable group.

Adults who provide unpaid care for 35 hours or more per week are also at high risk of low mental wellbeing compared to those who are not in a caring role, or those who provide fewer hours of care each week (Scottish Health Survey 2012, 2013). These results differed across gender; with female carers significantly more likely to respond negatively when asked if they have 'been feeling relaxed'.

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