

joining the dots – making healthcare work better for the local economy

Edited by Rose Gilroy and Mark Tewdwr-Jones



joining the dots – making healthcare work better for the local economy

Edited by Rose Gilroy and Mark Tewdwr-Jones

Published by The Smith Institute

This report represents the views of the authors and not those of the Smith Institute.

© The Smith Institute February 2015

Contents

Introduction: Joining the dots – making healthcare work better for the local economy	
Professor Rose Gilroy, Professor of Ageing, Policy and Planning and Director of Engagement at the School of Architecture, Planning & Landscape at Newcastle University, and Professor Mark Tewdwr-Jones, Professor of Town Planning at the School of Architecture, Planning & Landscape at Newcastle University	6
Chapter 1: Geographical health differentials and their association with employment levels – taking the 'long view' on healthcare and local economies	
Professor Sarah Curtis, Professor of Health and Risk in the Department of Geography and the Institute of Hazard, Risk & Resilience at Durham University	12
Chapter 2: Much more than healthcare – making more of the NHS's role in tackling poverty	
David Buck, Senior Fellow in Public Health and Health Inequalities at the King's Fund, and Joni Jabbal, Policy Officer at the King's Fund	20
Chapter 3: Health and well-being in working life	
Professor Dame Carol Black, Principal of Newnham College, Cambridge, Expert Adviser on Health and Work to the Department of Health, and previously National Director for Health and Work	32
Chapter 4: Work and health – a whole-system approach	
Christopher Pope, Strategy and Policy Manager at New Economy	40
Chapter 5: Regional dimensions to health, obesity and alcohol consumption	
Dr Tim G Townshend, School of Architecture, Planning & Landscape at Newcastle University	50
Chapter 6: Age-friendly city – Newcastle, ready for action	
Professor Rose Gilroy, Professor of Ageing, Policy and Planning and Director of Engagement at the School of Architecture, Planning & Landscape at Newcastle University, and Ann Schofield, Newcastle City Councillor	58

Chapter 7: London health and growth – a challenge for governance

Pamela J Chesters (writing in a personal capacity), Chairman of the Central London Community Healthcare NHS Trust and Chair of Anchor Trust **66**

Chapter 8: NHS reorganisation – a story of turbulent governance and changing institutions

Eugene Milne, Director of Public Health at Newcastle City Council, Honorary Professor in the Durham University School of Medicine & Health, and Honorary Senior Clinical Lecturer in the Institute of Ageing & Health at Newcastle University **74**

Introduction: Joining the dots – making healthcare work better for the local economy

National, regional and local action to combat health inequalities is widely accepted as critical to creating prosperous and sustainable communities. According to the 2010 Marmot review,¹ there is not only a strong social justice case for reducing health inequalities but also a compelling economic case. It is estimated that health inequalities cost over £30 billion a year in lost productivity and welfare/health costs. Health secretary Jeremy Hunt has stated: "local areas must work together to address health needs of their population and make a real difference in tackling health inequalities".

Policy makers are asking what more health and social care can contribute towards local and regional economies (the sectors combined are the nation's largest employers and account for 8 percent of economic output). Can communities benefit from more joined-up (cross-boundary) planning and investment of health and social care? Are local economies making the most of healthcare procurement and employment policies? What role can the life sciences industries play in local growth? Can the new agencies (such as local enterprise partnerships, city regions, and health and well-being boards) work effectively together? Will the restructuring of the NHS be a help or a hindrance? And what is best practice in maximising the opportunities from local/regional healthcare economies?

This collection of papers provides a series of reflections on the critical relationship between health and the economy. Against a background of fiscal restraint, the debate has narrowed to one of the economics of healthcare and specifically whether the UK can afford the quality of health service that is demanded. This publication seeks to rebalance the discourse through consideration of six interrelated issues:

- How does good health contribute to economic growth?
- Who should take responsibility for creating the conditions for good health and well-being?
- What opportunities for holistic action are delivered by the shift in managerial responsibilities for public health?
- What is the role of healthcare in addressing income as well as health inequalities?
- What contribution does the healthcare system deliver to the UK economy in its own right?
- What is the impact of the shifting governance of healthcare systems?

1 *Fair Society, Healthy Lives* (2010)

As Chris Pope of Greater Manchester's economic development agency, New Economy, contends: "The link between work and health is close, enduring and multi-dimensional." It is well evidenced that health performance and economic performance are strongly interlinked. Wealthy nations tend to have healthier populations with longer life expectancies. Good health, understood as a form of human capital, can be a source of individual well-being but also of local, regional and national productivity. This was understood in the 19th century with the birth of public health and town planning. It also prompted the Victorian model village builders – Rowntree, Salt and Cadbury – to provide their workforce with good-quality housing, gardens and places for community leisure, because they recognised that both productivity and profit would be enhanced by pro-health investment.

In this volume several commentators consider the social and economic determinants of health. David Buck and Joni Jabbal of the King's Fund consider how those with poorer health are vulnerable to poverty and worklessness, while Professor Sarah Curtis of Durham University's Institute of Hazard, Risk & Resilience presents evidence that links employment status to health outcomes. It is not simply that an individual who is unemployed may suffer worsening health but, regardless of individual work status, in an area of poor employment there is generally poorer health compared with those localities enjoying higher employment rates overall. Cause also for sombre reflection is the long shadow cast over the health of those who grew up in areas experiencing severe economic crisis (again, regardless of their subsequent individual increase in prosperity and work-rich adult lives). This chimes with the words of David Butler-Jones, the Canadian chief public health officer: "Every dollar spent in ensuring a healthy start in the early years will reduce the *long-term costs* associated with health care..., unemployment and welfare."²

Curtis emphasises the importance of retaining a local economic perspective when allocating NHS resources, given the proven linkage between economic and health disadvantage. She suggests that additional investment has ameliorated disparities in health. In the UK, the NHS is a major employer, so additional investment creates potentially dual benefits of improved healthcare and more "health-enhancing" jobs. As Buck and Jabbal discuss, the debate about NHS staff is often confined to its medical personnel, while what may have greater pro-poverty impact is the NHS's employment of ancillary staff; the increasing sign-up by NHS employers to paying a living (as opposed to minimum) wage; and a commitment to develop a social value approach to employment and commissioning.

² Butler-Jones, D *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2008: Addressing Health Inequalities* (2008) (<http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/pdf/cpho-report-eng.pdf>)

If childhood poverty and deprivation arising from parental unemployment have been the root of current health inequalities, what future legacy is the UK building for those living in areas characterised by under-employment, zero-hours contracts and the minimum wage? As Professor Dame Carol Black, government adviser on health and work, considers, it is not work *per se* but “good” work that delivers health and well-being benefits. Black and Pope both discuss how a return to work can be seen as part of a strategy for return to wellness for people with physical and mental health conditions and how better integration between health and employment sectors might support individual action. Currently these are separately funded and are not designed to integrate but, as Pope demonstrates, creative thinking by commissioners exploring upstream investment in preventive action as well as support to get people back to work has, in Greater Manchester, delivered cost-effective benefits. The problems of bringing together services that operate in separate silos is one that many authors discuss.

As Newcastle University’s Professor Rose Gilroy and Ann Schofield of Newcastle City Council argue, there is a broader need for employers to develop creative strategies that explore employment practices, workplace design and cultures that will facilitate retention of an ageing workforce, with the aim not only of increasing local and national economic productivity but also of ensuring that the health-preserving benefits of good work are enjoyed for longer with (presumably) less pressure on health and welfare budgets.

The Health and Social Care Act 2012 moved responsibility for public health out of the NHS and into local authorities, with new duties laid upon both to lead strategic planning to tackle health inequalities. Several contributors (Curtis, Black and Pamela Chesters, chairman of the Central London Community Healthcare NHS Trust) consider the role of health and well-being boards and the greater possibilities of aligning health and local economic agendas through the potential to broaden local authority officer membership and by inclusion of the local enterprise partnership. Conversely, Pamela Chesters (writing in a personal capacity) discusses how, in London, the LEP was tasked with understanding the economic contribution made by the health sector and its potential for innovation and wealth generation.

Dr Tim G Townshend of Newcastle University explores the new public health agenda of obesity and alcohol in the context of two very different UK regions, with different health outcomes. Townshend explores how these regional inequalities impact on the current and future health chances of adolescents, as well as how the ability of a local authority to invest and its investment choices in providing youth services and facilities creates or diminishes opportunities for young people’s healthy social development. In

the context of public health, the lack of pro-youth investment by Northern post-industrial cities, coupled with place-marketing strategies promoting an alcohol-based night-time economy, may erode pro-health choices for young people, with subsequent consequences for their adult lifestyle and health.

Gilroy and Schofield take up the role of place in exploring how the local authority in one Northern post-industrial city, motivated in part by deep budget cuts in the face of unmet social care needs, is trying to take an ambitious preventive strategy. The commitment to work towards age-friendly city status has as its core belief that health and well-being are maintained by a public-private partnership in shared concern for and shared investment in places that support people through the life-course. The ability to move beyond discussion to change on the ground is mired in organisational cultural differences and deeply felt job insecurity by local authority officers, which does not create an ethos of innovation.

The importance of context is discussed by Chesters, who explores public health delivery as it plays out in London, where the highly complex governance landscape is exacerbated by geographically ill-aligned responsibilities and an increasing and highly mobile population characterised by extremes of wealth and deprivation. Chesters provides insights into the organisational cultures of local government and the NHS, concluding that commitment and personal leadership are needed to get the best out of each.

As many contributors in this collection assert, the health of the UK relies on many factors: good housing; quality of education and employment opportunities; and the extent of local services and quality of place in which a person grows up and grows old. The health inequalities that are playing out are a consequence of neo-liberal reform as well as pro-London economic strategies. Healthcare services are left to deal with the consequences of decisions made in other political arenas. How these healthcare services should be organised to create maximum effectiveness at least cost is the focus of Newcastle public health director Eugene Milne's contribution, which unpacks the changes to public health and to NHS delivery.

Milne challenges the automatic assumption that preventive action will reduce need and dampen demand, and calls for an understanding of the psychological and social benefits of integrated and alternative care, while highlighting the need for investment in medical research and short-, medium- and long-term prevention. Health and cost-containment objectives could be better delivered if more people lived out a greater proportion of their lives in good health. Current NHS reforms are not likely to deliver change, not only because of a funding shortfall but also through the erosion of appropriately situated and accountable governance capacity.

Geographical health differentials and their association with employment levels – taking the 'long view' on healthcare and local economies

It is well established that there are significant local variations in population health across the country in England and Wales (and in the UK as a whole). In areas where health is worse, additional demands will be placed on healthcare services for treatment of illness. Given that some of these health differentials are avoidable, it is clear that more needs to be done to address the determinants of health and illness, through public health measures and preventive medicine.

This chapter discusses some of the reasons why it is not justifiable to argue that this health inequality can be tackled simply by encouraging individuals to change their health-related behaviours (though this may be part of the solution.) We also need to take action based on the evidence that a significant part of this health difference is associated with the wider determinants of health in the local areas where people live. For example, links between population health and the economy, particularly processes related to the labour market, cannot be ignored. Furthermore, the National Health Service and its partners in the health and social care system need to ensure that resources are allocated to different parts of the country in a fair way that takes account of health variation and to consider how their role as employers, as well as providers of healthcare, is important for the health of the population.

The scale of health inequality across the country is significant and has been persistent or increasing in recent decades.¹ Most studies of recent patterns of inequality in common illnesses such as cardiovascular diseases and cancers suggest that inequalities between socioeconomic groups in the population have recently been persisting or widening.² Research suggests that there are links between growing economic inequality and inequalities in health.³

1 Dorling, D *Unequal Health: The Scandal of Our Times* (Policy Press, 2013)

2 Bajekal, M, Scholes, S, O'Flaherty, M, Raine, R, Norman, P and Capewell, S "Unequal Trends in Coronary Heart Disease Mortality by Socioeconomic Circumstances, England 1982-2006: An Analytical Study" in *PLoS One* no 8 (2013); Ellis, L, Coleman, MP and Rachet, B "How Many Deaths Would Be Avoidable If Socioeconomic Inequalities in Cancer Survival in England Were Eliminated? A National Population-based Study, 1996-2006" in *European Journal of Cancer* no 48 (2012), pp270-278; Martin, LG, Schoeni, RF, Andreski, PM and Jagger, C "Trends and Inequalities in Late-life Health and Functioning in England" in *Journal of Epidemiology and Community Health* no 66 (2012), pp874-880; Scholes, S, Bajekal, M, Love, H, Hawkins, N, Raine, R, O'Flaherty, M and Capewell, S "Persistent Socioeconomic Inequalities in Cardiovascular Risk Factors in England over 1994-2008: A Time-trend Analysis of Repeated Cross-sectional Data" in *BMC Public Health* no 12 (2012)

3 Barr, B, Taylor-Robinson, D and Whitehead, M "Impact on Health Inequalities of Rising Prosperity in England 1998-2007, and Implications for Performance Incentives: Longitudinal Ecological Study" in *BMJ* no 345 (2012); Moeller, H, Haigh, F, Harwood, C, Kinsella, T and Pope, D "Rising Unemployment and Increasing Spatial Health Inequalities in England: Further Extension of the North-South Divide" in *Journal of Public Health*, no 35 (2013), pp313-321

These inequalities are apparent for whole communities, as well as for individuals. We can best compare population health for local areas using age- and sex-standardised measures, which relate to all residents and which show variations in health outcomes that cannot be explained by local differences in the age and sex composition of the population. For example, in 2012 the quintile group of 69 local authorities in England and Wales with the worst age- and sex-standardised mortality rates had levels in the range of proximately 1,066 to 1,297 per 100,000 population, while the quintile group of 70 local authorities with the best mortality rates ranged from 731 to 886 per 100,000.⁴

The 2011 population census also showed that there continues to be significant variation among local authority areas in the proportion of the population reporting a long-term health problem or disability. When English local authorities are ranked according to the age- and sex-standardised morbidity ratio based on these data, we find that (compared with an "average" value of 100, representing the typical level in England overall) the "healthiest" quintile (of local authorities) have values ranging from 65 to 82 (at least 18 percent better than the national average). By contrast, the "least healthy" quintile on this measure have values ranging from 111 to 142 (at least 11 percent worse than the average).⁵ Thus death rates and levels of long-term illness continue to vary across the country. Although progress has been made over time in reducing the average mortality rate for the country as a whole, geographical inequality in the risk of death and illness remains important.

A significant body of evidence shows that these variations in health are closely related to a number of social and economic health determinants that are linked to the wider environment in which we live and are not explained purely by individual or family risk factors. These wider determinants of health include employment conditions and levels of employment that impact on communities. Higher rates of unemployment and low employment rates⁶ as well as poor, insecure working conditions⁷ are associated with worse health. A number of causal pathways may account for these associations. These include material poverty caused by low income, physical harm due to unhealthy working environments, and psychosocial processes causing stress and emotional distress, which are damaging to both mental and physical health.⁸ These relationships between employment

4 Office for National Statistics "What Is the Mortality Rate in Your Local Area and How Does It Compare?" (2014)

5 Author's analysis using 2011 census data available from NOMIS at <https://www.nomisweb.co.uk/census/2011>

6 Moeller et al, op cit; Riva, M and Curtis, SE "Long-term Local Area Employment Rates as Predictors of Individual Mortality and Morbidity: A Prospective Study in England, Spanning More Than Two Decades" in *Journal of Epidemiology and Community Health* no 66 (2012), pp919-926

7 Ulijaszek, SJ "Do Adult Obesity Rates in England Vary by Insecurity as Well as by Inequality? An Ecological Cross-sectional Study" in *BMJ* open no 4 (2014), e004430-e004430

8 Bambra, C *Work, Worklessness and the Political Economy of Health* (Oxford University Press, 2011); Marmot, M *Fairer Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*, the Marmot review (Marmot Review) University College London, 2010) (www.ucl.ac.uk/marmotreview)

conditions and health apply to whole communities, and not only to people who are of working age and are employed or seeking work. This underlines that wider conditions in the area of residence are important for one's health, as well as individual health-related behaviours or personal social and economic characteristics.

Our recently published research⁹ also shows that these relationships operate over long time scales. Not only do *current* employment conditions relate to varying population health in local areas, but also the *longer-term trend* in employment in a local area has an additional effect. This research used information from the Longitudinal Study for a very large sample of the population from all local authorities in England. For each person, the Longitudinal Study recorded reported health outcomes in terms of long-standing illnesses and mortality, and also a number of other socio-demographic attributes that might be important for their health. For the period 2001-2008 the health indicators were linked to data recording trends in employment rates in their area of residence during 1981-2008 (relative to the national average). People living in areas with continuously higher employment since 1981 had better health than those living in areas with persistently lower levels of employment over time. This association is independent of individual social and economic attributes of people in the sample. Long-standing illness was even more strongly associated with long-term trends in area employment than with the area employment rate in 2001, the year when this health outcome was measured. Those living in areas where employment levels had been very low around 1981, but had increased to be close to the national average by 2001, had somewhat better health than in areas with persistently low employment, but they still showed a health disadvantage compared with areas having the highest rates of employment.

Also, in other work¹⁰ we have examined health for the people in areas with a heritage of coalmining industries. Not all ex-coalfield areas showed the same degree of health disadvantage, but some were reflecting a similar impression of a disadvantaged economic heritage associated with deindustrialisation, which was linked with poor health outcomes persisting for a long period after the closure of coalmines. Furthermore, there is evidence that the experience of living in an area undergoing severe economic crisis can cast a long shadow over one's health, not only over a couple of decades but over a lifetime. This is illustrated in another study,¹¹ which examined information on the health of people in the

9 Riva and Curtis, op cit

10 Riva, M, Terashima, M, Curtis, S, Shucksmith, J and Carlebach, C "Coalfield Health Effects: Variation Across Former Coalmining Communities in England" in *Health and Place* no 17 (2011), pp588-597

11 Curtis, S, Southall, H, Congdon, P and Dodgeon, B "Area Effects on Health Variation over the Life-course: Analysis of the Longitudinal Study Sample in England Using New Data on Area of Residence in Childhood" in *Social Science and Medicine* no 58 (2003)

Longitudinal Study recorded in 1991, linked to data on their place of residence in 1939. Those who as children had lived in areas affected most severely by the 1930s depression (where there were high levels of economic deprivation and unemployment) still showed additional risks of health disadvantages, more than 50 years later in 1991, which were not explained by their more recent circumstances.

These findings suggest that it is important to take a long view on health and related healthcare needs. Areas affected by very low levels of unemployment, especially where low employment levels persist over a long period, are at particularly high risk of poor health. This pattern may take a very long time to reverse, even where employment rates subsequently improve over time.

How can healthcare work better to be sensitive to local employment patterns?

To some extent the relationships between area employment rates and health have been recognised in the way that NHS resources have been distributed around the country, since the indicators of socioeconomic deprivation (which include information relating to employment and unemployment) have been included in resource allocation formulae used to determine the way that funds are allocated to different areas for health service provision. However, there has been recent controversy over removal of deprivation weightings from the NHS formulae.¹² The research reported above underlines the point that it is important to retain information about local economic conditions in resource allocation formulae because they are linked to health disadvantages that are not accounted for by demographic variables such as age or sex. Also, the particular health disadvantages associated with long-term low employment rates should be fairly recognised in the way that NHS resources are allocated, because these wider determinants of health have effects that are difficult to eradicate quickly, and they impact on long-term illnesses that increase the need for healthcare in whole populations at the local level.

Research has shown¹³ that the additional investment of NHS resources in areas with higher levels of socioeconomic deprivation has probably reduced the disparities in population ill health due to conditions amenable to healthcare. Unless these additional healthcare needs in poor areas continue to be recognised, we may begin to fall further behind in the slow process of reducing health inequality linked to local economic

12 Bamba, CL and Copeland, A "Deprived Areas Will Lose Out with Proposed New Capitation Formula" in *BMJ* no 347 (2013); Charlton, J, Rudisill, C, Bhattarai, N and Gulliford, M "Impact of Deprivation on Occurrence, Outcomes and Health Care Costs of People with Multiple Morbidity" in *Journal of Health Services Research and Policy* no 18 (2013), pp215-223
13 Barr, B, Bamba, C, Whitehead, M and Duncan, WH "The Impact of NHS Resource Allocation Policy on Health Inequalities in England 2001-11: Longitudinal Ecological Study" in *BMJ* no 348 (2014)

disadvantage. Targeted special measures in terms of health promotion and preventive treatment, as well as medical care for ill health, may be important if the NHS seeks to mitigate the impact of growing inequality between communities where employment rates and working conditions are generally good, as compared with places where economic disadvantage and low levels of employment are more prevalent.

In many of the areas where employment rates are relatively low and health is relatively poor, the health and social care sector is also important as a source of employment, as well as contributing to regional economic outputs. For example, for the group of areas with long-term low levels of employment and poor health outcomes in 2001-2008, described above,¹⁴ data from the 2001 census showed that a relatively large proportion (over 12 percent) of those in work were employed in health and social care. In contrast, in the group of areas with continuously higher levels of employment and a healthier population, only 9 percent of the working population were in this sector. Thus the NHS and related employers play a role with double benefits to local populations where economic conditions are relatively poor. Not only do health and care agencies work to address the relatively high levels of healthcare need in these areas, but also they help to support local employment.

In its role as one of the largest employers nationally, the NHS probably helps to bring long-term advantages to the wider community through employment opportunities, and to moderate the additional need for healthcare that arises where employment rates are low. There may be new strategies to pursue, through recruitment and service procurement practices, which would seek to maximise employment in the NHS for those living in areas most affected by low employment rates. The recent configuration of health and well-being boards may have created new opportunities. Those in local government responsible for local economic strategies to support employment levels may now be better placed to work in collaboration with NHS/public health partners to forge links in local planning that aim to build positive synergies between health, healthcare and employment (including employment in the health sector). However, these benefits will be more difficult to achieve if NHS and social care resources are cut, particularly if these cuts impact most severely on areas where employment is already low.

Overall, then, it is essential to "join up the dots" that connect the healthcare system and the local economy. Doing so helps us to understand that the two are inextricably linked. To treat them as separate from a policy and practice perspective will be

¹⁴ Riva and Curtis, *op cit*

damaging in terms of worsening disadvantages for local economies that are already in difficulties, further escalation of rising pressure of demand on the health and social care sectors, and growing health inequality in the population.

Acknowledgement

My thanks go to colleagues at the NOMIS centre, Durham University, for their advice regarding suitable data sets for me to use for some of the analysis reported here. (The findings, text and opinions are the author's own.)

Much more than healthcare – making more of the NHS's role in tackling poverty

As Nigel Lawson famously said, the NHS "is the closest thing the English have to a religion".¹ Our health service remains highly prized, despite concerns about the impact of the NHS reforms and recent well-publicised issues of quality.² We as a nation are wedded to the NHS and its core principles of universal free services: in polls, over 70 percent consistently support this universalism, arguing against the retreat of the NHS becoming a safety net for the poor.³

But it is less clear that the most is being made of the NHS's enduring principles, or its economic might in wider ways, in particular the battle against poverty. This chapter reviews how and to what extent the NHS already adapts to, mitigates, reduces and prevents poverty – and importantly, within current funding and structures, how it can make a much greater contribution.

While this chapter focuses on the NHS in England, we draw on work from the UK as a whole in what follows.

The NHS and its effect on poverty through the delivery of care and treatment

Paying for and accessing care

The NHS *adapts* to poverty as part of its principle of universalism. Our current system, based on the twin principles of care free at the point of use (funded primarily through taxation) and equity in provision mean that in theory the NHS is "well adapted" to poverty.

Being unable to pay for healthcare has very significant effects on poverty in many other countries. For example, in the US out-of-pocket healthcare expenses account for almost a quarter of income for those below the official poverty line,⁴ while in many European social insurance systems, patients have to pay charges at the point of use, although much can be clawed back at a later date. The NHS does consistently well in international comparisons of financial barriers to accessing healthcare, with fewer people reporting cost-related access barriers than in our major comparator nations.⁵ Where there are charges, over 90

1 Lawson, N *Memoirs of a Tory Radical* (Bantam Press, 1992) p613

2 <http://www.kingsfund.org.uk/projects/bsa-survey-2012>

3 See: chapter 30, <http://www.bsa-30.natcen.ac.uk/downloads.aspx>

4 De Navas-Walt, C, Proctor, BD and Hill Lee, C *Income Poverty, and Health Insurance Coverage in the United States: 2005* Consumer population report (US Census Bureau, 2006)

5 <http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Nov/Access-Affordability-and-Insurance.aspx>

percent of prescriptions are exempt from charges due to severe need⁶ and there is other help available, for instance on travel costs, for those on low incomes and in receipt of benefits.

When put up against comparable healthcare systems, the NHS also comes out very well on important indicators of equity in provision. Controlling for need, the probability of visiting an NHS GP is not related to income, and alongside the Netherlands the UK is also by far the least pro-rich among all comparator nations in terms of access to specialists.⁷

However, we should not blind ourselves to areas where the NHS could do better for those in or at risk of poverty – in particular in the early years of life and for people with long-term conditions, including mental health problems.

There is now incontrovertible evidence that our experiences in the early years of life (and in the months before birth) have lasting consequences for our future life chances.⁸ The NHS, in its role at the cradle, therefore has a core role to play in helping create the conditions for better early lives. A good example is the Healthier, Wealthier Children initiative⁹ in Glasgow, which used early-years staff to identify, intervene and refer parents whose children were in, or at risk of, experiencing child poverty, using health visitors, antenatal staff and others to identify poverty problems and refer people on to the government Money Advice Service. Since the initiative's launch in October 2010, a cumulative total of 5,003 referrals resulted in just over £4.5 million in annual financial gain for those who accessed the advice service. In England, the Family Nurse Partnership focuses on poor and vulnerable first-time young mothers through intensive support. The evidence base for the Family Nurse Partnership is strong and growing for both mothers and children, including long-term improvements in mental and behavioural health, greater school readiness, fewer child injuries and reductions in crime.¹⁰ There is also evidence of reductions in welfare and other government assistance payments, increase in father presence and stability, and greater maternal employment, and by inference, a reduction in child poverty.

The NHS needs to do much more to help many with long-term conditions (LTCs) from slipping into poverty. LTCs are defined as persistent health issues that cannot be cured but can be controlled to some extent, such as arthritis and depression. People with mental health problems are at particularly greater risk of poverty – approximately 70 percent of

6 <http://www.hscic.gov.uk/catalogue/PUB11291>

7 <http://www.cmaj.ca/content/174/2/177.full.pdf>

8 <https://www.gov.uk/government/publications/early-intervention-the-next-steps--2>

9 <http://www.hsj.co.uk/resource-centre/best-practice/public-health-resources/nhs-innovations-on-child-poverty/financial-inclusion-interventions/5046943.article#.U99RwGNrv0V>

10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215542/dh_128008.pdf

individuals with psychotic disorders are economically inactive, while people with common mental disorders such as depression experience some of the highest rates of absence from work, premature retirement and long-term unemployment.

More than 15 million people, three in every 10 of us in England, have an LTC, and care for people with LTCs accounts for 70 percent of the health and social care budget in England. Increasingly too, people are experiencing more than one LTC at a time, which significantly complicates care and raises costs. By 2018 almost 3 million people in England will have three or more LTCs, compared with fewer than 2 million in 2008.

The increasing focus on integrated care¹¹ is one of the policy responses to this increasing demand and complexity. But what is less well known, or reflected in health policy debate or practice overall in the NHS, is how socially skewed experience of LTCs is. Those from lower socioeconomic groups are much more likely to experience them, and to experience them more severely.¹² Deprivation channels more people into having multiple long-term conditions, as opposed to having single or no long-term conditions; one in three patients from the most deprived postcodes have three or more LTCs, compared with only 7 percent of the least deprived areas.¹³

LTCs are also by definition conditions that people live with in their everyday lives, and they therefore affect work. Earlier onset of LTCs – itself linked to socioeconomic status – is linked to reduced likelihood of entering and greater likelihood of earlier exit from the labour market, if the LTC limits everyday activities. Overall, more than half of those with an LTC consider their poor health is a barrier to the type or amount of work they can do, rising to over 80 percent when someone has three or more conditions.¹⁴

LTCs are therefore likely to be a core factor keeping people on lower incomes and in poverty, and in “sending” people into increasing unemployment, compromising individual and family income levels and increasing poverty risk. The trend is for this to become more of an issue over time as the population ages. How the NHS “adapts” to the increasing number of people with LTCs and co-morbid mental health problems is clearly very important in terms of the knock-on implications for reducing the risk of poverty.

So, in conclusion, compared with many other systems the NHS does exceptionally well because of its core principles. But, in fulfilling its goal of better care and health for all, it can

11 See, for example: <http://www.kingsfund.org.uk/topics/integrated-care>

12 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

13 <http://hrs.sagepub.com/content/18/4/215.full.pdf+html>

14 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

also do much more to alleviate and mitigate poverty, particularly in the early years of life, and for those with mental health issues and those with (or at risk of) early-onset LTCs.

But, beyond this, are we being blinded by the NHS's role in treatment and care? Are we making the most of its impacts on poverty through its economic might?

The wider impact of the NHS on poverty

While the NHS is experiencing the longest period of funding restraint in its history, the latest data on health spending in England shows that the Department of Health still spent £110 billion in 2013/14.¹⁵ The wider government spending slowdown is so large that even though real NHS funding has reached a virtual standstill, the IFS estimates that the health service's share of overall public funding will have risen from 13 percent in the late 1970s to 28 percent in 2014/15.¹⁶

So, at a time when NHS spending is becoming more important to local economies rather than less, the NHS needs to be recognised, valued and challenged on its role in *reducing* and *preventing* poverty. The prime route for this is not through the delivery of treatments and care, but through its scale, scope and reach in society – as an economic giant, employer and commissioner.

The NHS delivers treatment and care that improves health directly and therefore influences poverty as set out above (and, of course, poverty also feeds back into effects on health, and consequent use of NHS services). But it also has other effects, which bypass the treatment effect. These are summarised in figure 1.

NHS services can be seen as the transfer of free services, or "benefits in kind", which would otherwise need to be paid for directly by individuals. Across the OECD region, in-kind government expenditure (publicly provided services such as health and education) equates to around 21 percent of people's disposable income; of this, healthcare is the biggest component, at 45 percent.¹⁷ Before this redistributive effect of public transfers, the UK is second only to Spain on income inequality, as measured by the ratio of the income of the richest quintile of the population to that of the poorest quintile. The distribution of NHS services acts to narrow this ratio by 13 percent and boosts its ranking ahead of Ireland and Italy.

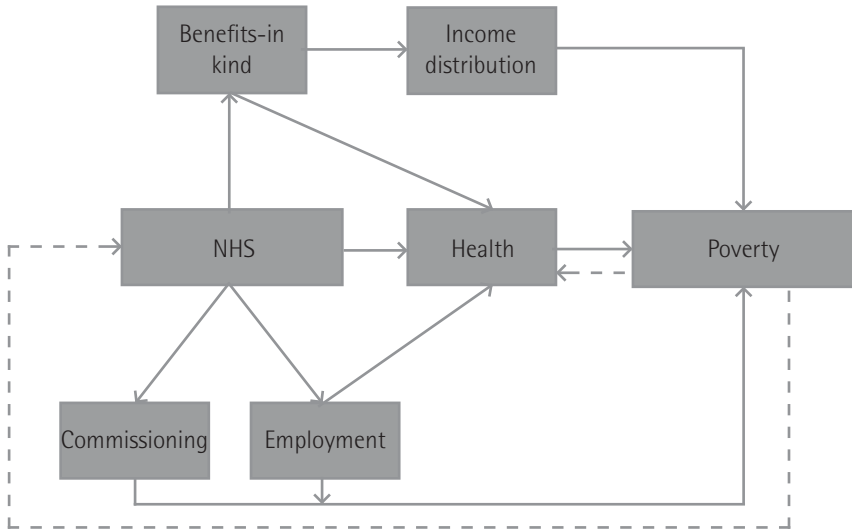
15 See: table 1, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335166/DH_annual_accounts_2013-14.pdf

16 <http://www.ifs.org.uk/publications/5651>

17 See: box 9.2, <http://www.oecd.org/els/soc/growingunequalincomedistributionandpovertyinoecdcountries.htm>

Figure 1: The NHS and its impacts on poverty – treatment and non-treatment effects

The NHS and income inequalities



The fiscal impact of NHS spending

The WHO set out the evidence for the link between healthcare spending and poverty in the context of developing countries in its *Commission on the Macroeconomics of Health*;¹⁸ more recently, the OECD estimates also suggests that public healthcare services have been important in maintaining spending in the recent recession. Across countries, the average multiplier effect of public healthcare spend has been about 3.6 – larger than almost all other categories of spending,¹⁹ and studies of Obama’s fiscal stimulus in the US suggest that the fiscal multiplier on Medicaid spending has been around 2.1.²⁰ Directly translating these estimates to the English or UK NHS is difficult given contextual and definitional issues. A study in Wales suggested the multiplier on local health spending was 1.78.²¹ To our knowledge there are no direct studies of the

18 <http://www.who.int/macrohealth/infocentre/advocacy/en/investinginhealth02052003.pdf>

19 <http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf>

20 Wilson, D *Fiscal Spending Jobs Multipliers: Evidence from the 2009 American Recovery and Reinvestment Act*, Federal Reserve Bank of San Francisco working paper 2010-17 (October 2011) (<http://www.frbsf.org/publications/economics/papers/2010/wp10-17bk.pdf>)

21 <http://www.newport.gov.uk/stellent/groups/public/documents/report/cont599382.pdf>

fiscal impact of English NHS spending, but it is likely that the multiplier would be in the range above.

The NHS as an employer

The NHS has a more direct impact on poverty due to its immense size and scope as an employer: through the scale of employment, its actions as a good employer and specific actions to employ specific groups.

Although the NHS employs hundreds of thousands of medical and related staff, arguably more important in countering poverty is its employment of over 1 million non-medical staff, about which there is hardly any policy debate. The best and most comprehensive data on the NHS as an employer is based on evidence submitted to the NHS Pay Review Body.²² Mean overall earnings for non-medical staff in the NHS in 2011 were around £25,600. However, this varies substantially, with total average earnings ranging from £16,800 to £57,000 depending on the organisation. Outside London, NHS pay is on average higher than private-sector pay.²³ The NHS is therefore a critical employer and source of income in local economies, through its employment of non-medical staff as much as its clinical staff.

More and more NHS organisations are also showing that they are good employers by signing up to pay the "living wage". Recent examples include the NHS in Tower Hamlets²⁴ and Great Ormond Street Hospital.²⁵ Other examples of accredited "living wage employers" include Wiltshire Ambulance Trust, Barts Health NHS Trust, the Royal College of Midwives, Derbyshire Community Health Services, and the Chartered Society of Physiotherapy.²⁶

The NHS has a powerful role to play in helping people into work through its own employment practice, such as in helping younger people who are not in employment, education or training (NEET) into work in the first place. One example of this is Guy's and St Thomas' Foundation Trust, which runs a range of programmes, including a "get into work with the NHS" scheme with the Princes Trust, which targets NEETs aged 16-to-24

22 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/22159_Cm_8501_AccessibleLR_1_.pdf

23 Based on the "geographical pay variation gap" (GPVG). This measures the difference between an NHS organisation's pay relative to the NHS average, and private-sector pay in that location relative to the private-sector average. For example, an organisation paying 5 percent more than the NHS average, but located in an area where private-sector pay is 10 percent above the private-sector average, would have a GPVG of -5 percent. Figure 6.26 in https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/22159_Cm_8501_AccessibleLR_1_.pdf shows the distribution of GPVG for NHS organisations in 2011.

24 http://www.towerhamlets.gov.uk/news__events/news/december_2013/tower_hamlets_health_and_wellb.aspx

25 <http://www.gosh.nhs.uk/news/press-releases/2013-press-release-archive/gosh-announces-pre-christmas-pay-rise-for-lowest-paid-workers-during-london-living-wage-event/>

26 <http://www.livingwage.org.uk/employers>

within the local community. The trust also has 16 partnerships with local schools, taking young people on work experience and partnerships with other bodies to deliver an employer-led recruitment programme to meet the trust's needs and demands, while reducing the numbers of long-term unemployed in the local area. It has also recently launched a mentoring scheme²⁷ whereby unemployed and otherwise NEET young people can get advice from trust staff on careers in the NHS.

The NHS as a commissioner of social value

The NHS commissions and procures services from third parties and therefore indirectly affects the pay and conditions of many more workers. Low pay among contract staff in the NHS – particularly for cleaning and other support staff – has been well documented.²⁸ The Royal College of Physicians has recently audited²⁹ NHS trusts and found that 83 percent (96/116) of responding trusts report that fair terms and conditions are included in the procurement conditions, while 68 percent (79/116) say that they insist on a living wage (around half of all NHS hospital trusts in total).

An area that has huge promise but remains little explored so far in terms of its relationship with poverty is the implications of the Social Value Act for the NHS.³⁰ This legal duty for public-sector organisations to consider how the services they commission and procure improve the economic, social and environmental well-being of the area could be a real game changer for the NHS, reshaping its procurement and commissioning to become more attuned to poverty strategy.

For the NHS to take social value seriously³¹ can have a transformative effect locally. Although it is early days, there are some examples starting to develop, including Waltham Forest's re-commissioning of its special educational needs transport services (with the winning contractor demonstrating how its employment of marginalised people created social value)³² and, on a more strategic level, Liverpool's Health Commission,³³ and Halton and Salford.³⁴ In Blackburn with Darwen, the local authority has been working with the local NHS (formerly the primary care trust) on the development of a social value approach to its commissioning, as part of a broader approach to social value across the range of its responsibilities (see panel).

27 <http://www.guysandstthomas.nhs.uk/news-and-events/2014-news/140211-mentoring.aspx>

28 http://www.york.ac.uk/res/fbu/documents/mlpinel_sep2001.pdf

29 http://www.rcplondon.ac.uk/sites/default/files/implementing_nice_web.pdf

30 <http://www.nhsconfed.org/Publications/Documents/building-social-value.pdf>

31 See some examples in other areas of public procurement here, <http://www.jrf.org.uk/sites/files/jrf/poverty-local-governance-full.pdf>

32 http://www.socialenterprise.org.uk/uploads/files/2012/03/public_services_act_2012_a_brief_guide_web_version_final.pdf

33 See p10 in <http://www.liverpoolexpress.co.uk/wp-content/uploads/2014/01/Health-commission-report-low-res-for-web.pdf>

34 <http://www.socialenterprise.org.uk/about/about-us/our-projects/delivering-social-value>

Blackburn with Darwen's approach to social value

Blackburn with Darwen has been doing three things to generate social value from its local spend:

- developing its own local "social value assessment tool" and piloting it within NHS contracts;
- analysing and maximising local public-sector spend with local businesses; and
- investing in local social enterprises as part of its public services reform.

Social value assessment tool

In 2012 Blackburn with Darwen Care Trust Plus (primary care trust), working with NHS commissioners, the local authority, the community and voluntary sector, established a group to develop and test a social value self-assessment tool. This was designed to enable providers to demonstrate the added social value they were creating. The NHS commissioning team agreed to take the responses to their social value self-assessment into account when awarding contracts. The social value self-assessment tool asks a series of questions over 10 domains:

- investing in the workplace through access to high-quality occupational health;
- increasing employability and providing high-quality employment opportunities for local people;
- reducing congestion and promoting sustainable travel;
- increasing prosperity and opportunity in the borough (through support for businesses);
- promoting community cohesion and diversity and equality;
- increasing educational attainment especially in English and maths;
- increasing social capital through developing opportunities for volunteering;
- increasing opportunities to aid people with learning disabilities into employment;
- carbon reduction; and
- rehabilitation of offenders or those with alcohol and substance misuse problems.

The tool has been tested with two of the largest local NHS trust service provider contracts for public health this year; next year they will be asked to develop an action plan to address any under-utilised opportunities for local social value development identified in the assessment. In addition, the prospect of universalising the tool's use across all major local public-sector contracts will be explored, along with its use in the PQQ process and to assess competitive tenders.

Source: For more details, please contact Dominic Harrison, director of public health at Blackburn with Darwen Borough Council. Tel: 01254 666933. Email: dominic.harrison@blackburn.gov.uk

The regional economic impact of the NHS

Through these routes above, the NHS is important in every local economy in England but it is much more important in relative terms to some than others. Analysis of Office for National Statistics data on productivity contributed by "human, health and social work activities", in terms of gross value added (GVA),³⁵ by region, gives an indication of this, given that the largest proportion of this will be NHS spending.³⁶

This shows that the North East is twice as dependent on this spending as is London, which is the least dependent as a proportion of GVA. Broadly speaking, higher economic dependency on NHS spending correlates with higher poverty rates. London is the exception, despite its concentration of healthcare (reflected in it having a large number of teaching hospitals and therefore the highest absolute GVA of all regions, accounting for between 17.5 percent and 18.8 percent of England's total). The capital is simultaneously less dependent on this spending than any other region, because of its wealth, and has a higher proportion of individuals living in poverty than any other region.

Making more of the NHS: moving forward, recognition and action

What this chapter has revealed is that, although the NHS affects poverty through its impact on health and in how services are designed for patients (for instance those with LTCs), it has a much wider influence beyond this. It in effect narrows income inequalities by about 13 percent and has a huge potential to reduce poverty through its employment, its economic scale in every community, its commissioning, and in the details of how funds are allocated to different parts of the NHS.

Yet discussion of this potential is almost entirely absent from the policy discourses on both health and poverty.³⁷ It is time to tackle this. So, surely the NHS should be given a specific policy objective to tackle poverty? Actually, our view is that it should not. Introducing a direct poverty reduction goal, while superficially appealing, would undermine the principles on which the NHS is built, and for which the English, and British, public value it. At the logical extreme, a poverty objective could lead to means-testing NHS services – as in social care. While this would be more pro-poor and redistributive, it would come at a very high cost: the NHS would be less efficient (as a national insurer with a narrower risk pool) and would be politically unsustainable.

35 GVA is one indicator of economic value. It differs from GDP in that it excludes taxes and subsidies (measures for GDP are not available regionally). For more on the definition of GVA, see: <http://www.ons.gov.uk/ons/guide-method/method-quality-specific/economy/regional-accounts/regional-accounts-methodology-guide.pdf>

36 See the international definitions here: http://unstats.un.org/unsd/publication/seriesM/seriesm_4rev4e.pdf

37 See the full version of this paper, for more on why this is the case.

We believe that within its budget and its current responsibilities the NHS can maximise its impact on poverty through a better alignment of its system levers, a widely shared and accepted "poverty narrative", and wider engagement with local partners and civil society.

This requires stronger leadership from the Department of Health and NHS England, especially in setting out expectations and a narrative on poverty (the framework at figure 1 could be useful for this); the sharing and highlighting of good practice; and production of guidance on what the Social Value Act implies for the commissioning of NHS services.

A more poverty-aligned system would mean an NHS that is aware of its existing impact on poverty; that is clear what the new duties on inequalities mean and how they relate to poverty reduction; where primary care is proactive and sees its role as changing the wider determinants of health as well as reacting to illness (as the Glasgow example shows); and that is expected to be, as well as rewarded and accountable for, doing better for people with mental health problems and LTCs and for child poverty.

We need an NHS that plays a leading role in civil society locally bringing its huge economic power into play more positively to tackle poverty – paying the living wage by default rather than by exception and commissioning for social value.

Acknowledgements

This paper draws heavily from work commissioned from the King's Fund by the Joseph Rowntree Foundation to inform its work on developing anti-poverty strategies for the UK.

Health and well-being in working life

A concern to remedy the human, social and economic costs of impaired health and well-being in relation to work and working life, and the health inequalities associated with them, lay at the heart of the *Review of the Health of Britain's Working Age Population: Working for a Healthier Tomorrow*.¹

There is consistent evidence that, for most people, work – good work – benefits their health and well-being, and conversely that prolonged worklessness is harmful. It is also evident that the conditions and experience of working life can affect health and well-being. Promoting good health and well-being and supporting people through ill health is not only good for individuals and their families, and for the wider community; it also benefits business and the economy.

Taking steps to promote good health and minimise the known avoidable risks to health brings responsibilities to almost everyone. The welfare state supports the exercise of that responsibility; it does not take it away. But responsibility does not lie with individuals alone. Through society's organised efforts it is a shared responsibility. It is a responsibility shared at national, regional and local levels, across government, with organisations and formal institutions at all levels, between such organisations and, crucially, within each one of them.

The issues were put into a larger social context and reinforced by the Marmot review. As Professor Sir Michael Marmot and others before him have convincingly shown, variations and inequalities in health and life expectation are associated with and most certainly influenced by a wide combination of social and circumstantial factors, often deeply embedded in cultural and socioeconomic experience and established beliefs and attitudes. Not only do such factors directly affect overall well-being, but they are also recognised as underlying causes of the medically defined causes by which we categorise much ill health.

We know too that individuals' responses to illness are likely to be influenced by similar cultural and economic factors. Those influences interact in complex ways. They present a continuing challenge to those who make policies, those charged with implementing those policies, and especially to health and business professionals whose practices are necessary keys to change and improvement.

The Marmot review concluded, "so close is the link between the nature of social arrangements and health inequalities that a debate as to how to close the health gap has to be a debate

¹ Black, C *Health of Britain's Working Age Population: Working for a Healthier Tomorrow* (Department of Health/Department for Work & Pensions, March 2008)

about what sort of society people want". This was put succinctly as six policy objectives:

- give every child the best start in life before school age;
- give all the chance to develop skills and opportunities to control their life chances;
- create fair employment and decent work for all;
- ensure a healthy standard of living for all;
- create and build communities and places that give people the control needed to live physically and mentally healthy lives; and
- strengthen the role and impact of prevention.

Each bears on preparation for and experience of working life, though the scope of this chapter is more limited.

Range of action

An initial emphasis on reducing the risks associated with sickness absence has broadened. It now includes action in the workplace to safeguard and improve the physical and mental health and well-being of employees and to promote collaboration between employers and healthcare organisations to ensure that individuals receive the range of support and health interventions they need. It reinforces the need for government, health, healthcare and social agencies, welfare agencies, employers and individuals to work together to support and enable productive and rewarding work for people with physical and mental health problems while also safeguarding and promoting sustained good health in those who are well.

These participants have common interests, although their perspectives, motives, incentives, attitudes, beliefs and priorities may differ. But whether the imperatives are to maintain individual and family well-being, strengthen social cohesion, reduce unacceptable health inequalities or improve organisational productivity and performance, there is a unifying thread.

A public health matter

The purpose of public health is to orchestrate concerted action to safeguard and promote good health across communities. The health and well-being of working people lies within the domain of public health and is high among the priorities of Public Health England (PHE). PHE is a key partner supporting public health within local authorities.

The Health and Social Care Act 2012 established health and well-being boards as a forum where key leaders from the health and care systems work together to improve the health and well-being of the local population and reduce health inequalities. The

boards bring together clinical commissioning groups and councils to develop a shared understanding of the health and well-being needs of the community. Their joint health and well-being strategies reflect policy objectives identified by Marmot.

Success greatly depends on the ability of health and well-being boards to bring leadership that transcends local organisational boundaries. They must reach across and draw together organisations whose first priorities range from maintaining and improving health and healthcare and essential social functions, to the successful conduct of business.

There is encouraging evidence of a will to make this happen. But boards are charged with exerting influence in the absence of an executive function, and it appears that there is some uncertainty about the respective roles and responsibilities of the different bodies in play. This might be a hindrance, raising issues that might best be addressed in an evolutionary way in the light of gathering experience and learning.

Health and work: core issues

Recent independent reviews and government responses have addressed the issues in detail. There are several interconnected elements. The first is to support and enable people of working age to enter employment. That is a core aim of welfare reform – “to help more people to move into and progress in work, while supporting the most vulnerable”. Its provisions complement strategies centred on health, work and well-being.

A foremost aim is to bring about necessary changes in understanding, behaviour and practice, wherever they bear on the interaction of health and work. Such changes should build on the foundations summarised earlier – namely, that for most people good work benefits their health and well-being, and that prolonged worklessness is harmful; that the conditions and experience of working life can affect health and well-being; and that promoting good health and well-being and supporting people through ill health is not only good for individuals, their families and the wider community but also benefits business and the economy.

There follows a need to find ways to support people with health conditions to stay in work, minimising the risk of unplanned absence and protecting them from needlessly moving into welfare dependency. The need becomes more pressing as the working population ages and increasing numbers are afflicted by the common health conditions of ageing – conditions that are still compatible with productive work.

Provided that individuals are given appropriate healthcare and advice, adequate workplace support (which might also include parallel support through the welfare system) and

workplace adjustment, and necessary support to overcome psychosocial barriers to work, for most people neither the common long-term conditions nor common mental health conditions (which are often linked) should be a bar to a fulfilling, productive and extended working life. Such provision may also be necessary to enable un-delayed return to work after sickness absence.

Mental health

Prominent among our current preoccupations are the employment consequences of common mental health problems that undermine resilience and well-being and limit performance. The Foresight Mental Capital and Well-being Project was a landmark in influencing policies and action in this regard.

At any time, one in six adults are experiencing a mental health condition. In many, often for fear of stigmatisation, it is private and hidden. Most of these people are of working age, are in employment and are valued. However, despite known means of support and treatment, many succumb. This is evidenced by the fact that mental illnesses have become the major driver for labour market exclusion.

People with common mental disorders are at high risk of poverty. They are strongly represented in other working-age benefits, especially income support and housing benefit.

Mental health conditions cost UK businesses £8.4 billion each year in sickness absence, and even more – estimated at £15.1 billion – in lost productivity. So for business reasons, besides moral imperatives, employers have a keen interest in ensuring that people with such conditions are supported to recover and retain their jobs; and, in the wake of any absence, enable them to return to work as soon as they can.

Given the protean impact of mental health problems – across all ages – and particularly taking into account the lengthening working life, there is a need for constant attention to policies, attitudes, behaviours and practices that can worsen such problems and those that can alleviate them.

While attending to mental health in the working-age population, we must acknowledge the common early onset of dispositions to mental health problems. The point is that recognition and intervention to strengthen resilience and minimise vulnerability should begin early. There should be concerted effort towards preventing problems, identifying emerging needs and intervening appropriately at various stages of the lifecycle; including at school, during the school-to-work transition, at the workplace, and when people lose

their job or move into the benefit system. Complementing personal action there should be a move towards integrating health, employment and, where necessary, social services.

An ageing population

Important questions have arisen as a consequence of increasing longevity and the corresponding need to extend economically active life. They are similar to questions about health and work at any age, but bring out issues that become more prominent in older members of the workforce.

Labour participation rates drop significantly after age 50, long before the usual pension age. Reasons for ceasing economic inactivity include poor health and increased caring responsibilities, which in many cases arise as a consequence of the poor health of family members.

Making progress

The question arises of how best to ensure provision of and timely access to the several modes of support that are currently delivered by different, often disconnected agencies. How might these agencies be brought together to act cohesively, with ready patient/employee access, at the right time?

Roles of health professionals

General practitioners, their specialist colleagues and other health professionals have key roles in explaining and promoting the importance of working life in relation to health. With clear exceptions, entering work, maintaining work and returning to work after sickness absence should be regarded as desirable outcomes in the face of disability, illness or injury.

The new approach to sickness certification is designed to change the previous emphasis on what a patient *cannot* do as a consequence of illness or injury or disability, to a more helpful view of what they *can* do. And it is designed to encourage better communication between all parties that have responsibilities in supporting return to work.

Further, a shift from job-specific assessment to a view on general work capability opens up possibilities for employee and employer to explore previously unconsidered opportunities for work.

Occupational health advice is patchy, and arrangements for giving coherent advice and support to employers and employees/patients on workplace, health, psychosocial and welfare matters are at an early stage. Today occupational health should not be limited to supporting staff with known health problems; it should also be about safeguarding and

promoting the health and well-being of all staff. We must reach further and strengthen the preventive function of occupational health – helping to keep staff fit and healthy and engaged in this aim.

The Health & Work Service, seen as key to forging an effective unified approach, is now being set up. The service aims to promote earlier intervention, particularly for those exceeding four weeks of sickness absence, to facilitate a return to work without unnecessary delays. This will include, among other things, a holistic initial assessment and on-going case management.

This service will be welcomed by employers and health professionals, particularly GPs, who often lack ready access to specialist occupational health advice. Importantly, it is believed that independent expert advice will greatly help employees, restoring confidence and helping to maintain their connection with the labour market.

Role of the workplace

Workplaces are key settings for improving people's mental and physical health, as well as their overall well-being. By addressing issues such as the working environment, employee engagement, work-life balance, healthy living and good communication, employers can improve the well-being of their workforce. In return, they will see increased productivity, and loyalty, reduced sickness absence, and a culture where individuals' skills can flourish. As well as making good commercial sense, investing in the health and well-being of staff is seen by many as part of an employer's responsibilities.

A CBI report – *Getting Better: Workplace Health as a Business Issue* – outlines how businesses can improve the well-being of their staff, and it provides a practical toolkit based on the experience of CBI members.

The Public Health Responsibility Deal aims to tap into the potential for businesses and other influential organisations to make a significant contribution to improving public health through their responsibilities as employers, as well as through their commercial actions and their community activities.

Employee morale, attitude and sense of well-being are critical determinants of organisational performance. Ensuring that employees are committed to their organisation's goals and values, and motivated to contribute to organisational success while enhancing their own sense of well-being, depends critically on their successful engagement. This requires managers to present a clear, strong strategic narrative, give their people focus and scope, treat them as individuals, coach and stretch them, allowing them an effective employee

voice, and display integrity by demonstrating stated values in their day-to-day behaviour.

Companies with highly engaged staff report employees taking an average of seven days absence per year, approximately half the quantity reported in low-engagement companies. Employees in high-engagement companies also report less workplace stress.

In the National Health Service, measures of staff engagement show a high correlation between good scores and a range of desirable outcomes for patients, with greater patient satisfaction and lower standardised mortality rates.

Presenteeism

There is increasing recognition of presenteeism. This is defined as being at work but not being able to function to maximum capacity, for reasons such as the work environment, poor managerial relations or unsupported poor health. It is thought to be an even greater problem than sickness absence. Presenteeism affects business performance in terms of productivity, quality and safety. It is often concealed and unrecognised, mostly revealed through workforce surveys, and difficult to measure objectively.

Conclusions

Dealing effectively with the health and psychosocial challenges of working life calls for supportive interventions at many points in the life course. Some will require years to take effect. But tested interventions offer the prospect of benefit rather sooner, to meet pressing current needs. Among them are well-defined changes in employer practices and in the attitudes and expectations of employees.

It is clear that a major factor is the culture of the workplace. This depends on good senior leadership and high-quality management, ensured through education and training. The findings of established staff surveys and patterns of sickness absence show that there is much to be done.

There is also a need for greater clarity on the roles of the welfare system, employing organisations and the health sector in promoting employment and well-being. This must include a reiteration of the importance of true partnership between these participants, with consideration of the strength of incentives for improving health and work outcomes by these organisations.

Work and health – a whole-system approach

The link between work and health is close, enduring and multi-dimensional. Macroeconomic policies to expand employment and improve individual health are mutually supportive and can help to address wider issues such as in-work poverty, and economic and health inequalities. Yet if services are not delivered in a joined-up manner, they can increase costs for the public sector and reduce the overall impact of each service on people's health and employment. To understand the importance of healthcare to the labour market, we must therefore explore its role in a wider context.

An effective and efficient health service should anticipate and respond to demand, and provide the right support at the right time. However, health services are currently facing huge cost pressures: increasing demand from older patients, and a propensity to respond to, rather than pre-emptively tackle, health conditions. The health system must take a closer look at these issues to discover how best to support the labour market and the wider local economy. Greater Manchester, which is very much at the forefront of national thinking around the future of public services, has begun to explore how this can be done. As the UK's biggest city region outside London, it has a lot to lose if it does not appropriately consider the wider impact of healthcare on the local economy, and act upon what it finds. Conversely, if it makes the changes and reforms that are needed, it has the most to gain.

However, Greater Manchester currently faces a stark fiscal reality: the public sector spends £5 billion more than is generated in taxes. This means that other areas of the country (mostly London) are funding this shortfall. Greater Manchester is in effect acting as a drag on national resources and the national economy. It becomes all the more important for public finances to be self-sufficient – to increase tax take and to reduce public-sector expenditure. Yet cuts in expenditure mean that either the level of public services, or the level of quality, will suffer. From an economic standpoint, Greater Manchester cannot allow that to happen. Many of the public services provided play a crucial role in the wider economy – with the health system in particular supporting and maintaining the local economy's biggest asset: its people.

Greater Manchester is only now returning to pre-recession levels of economic output. At the same time, its productivity – the amount produced in the economy per person – is lower than the national average. In order to deal with the public-sector deficit, Greater Manchester must first and foremost grow the economy – this means more businesses, more jobs and greater productivity. Increasing the number of residents in work, and supporting them to stay in employment, can both increase the amount taken in income tax and reduce overall welfare costs. By focusing on employment as a primary outcome,

Greater Manchester can therefore make significant progress towards reducing the fiscal deficit. Yet that relies on efficient and effective public services that support economic development and growth.

At the same time as growing the economy, Greater Manchester needs to respond to increased demand for public services while also cutting costs. The scale of austerity measures currently in existence, alongside the expected future reduction in public service funding, is significant. To take an example, New Economy, Greater Manchester's economic development agency, estimates that over the next three years welfare spending in Greater Manchester will fall by around 19p for every £1 of public money currently spent. Though that figure may seem relatively small, it amounts to £1.67 billion over three years. That is equivalent to the total sum of benefits paid to all 62,600 job seekers and all 140,950 individuals on health-related benefits in Greater Manchester. Similarly, the labour market legacy of the recession – higher unemployment, and longer-term unemployment – generates associated demand and costs for health services.

Public services – health, education, welfare, social services – have a direct impact on one another. When the skills system fails to train residents for the jobs available, the costs of unemployment will eventually fall onto the welfare system. If employment support services do not adequately support residents back into work, our health system bears the brunt of the physical and mental ill health costs resulting from long-term unemployment. Yet despite the obvious connections, our public services are still funded in silos. As a result, when public services are expected to cut costs, they focus exclusively on applying a salami-slicing approach to individual services. Cutting small funding amounts across the board can lead to reductions in both quality and volume of service; in addition, they can have a direct impact on the costs of other public services. Crucially, this approach will not reduce costs in the long run; it will simply push the weight of service costs onto already well-burdened shoulders in other parts of the public sector. Greater Manchester has already seen this. Since 2008, local authorities have cut expenditure on services totalling around £500 million. Yet at the same time, the rising costs of welfare and health have more than offset these reductions.

These two pressures – the need to deliver services that support the growth of the economy; and the need to cut expenditure in a way that doesn't simply shift costs to other parts of the system – create a dynamic for change. Greater Manchester has therefore taken a closer look at what is delivered *in the round*, and how public services as a whole can deliver better outcomes for less. The city region has begun to reform the way services are delivered through a range of community budget pilots, reforming public services in a way that seeks to create a single source of funding to tackle complex social issues. By pooling resources

and taking a holistic view of public services, Greater Manchester can begin to generate the savings the city region needs to make.

Greater Manchester is not alone. Many towns and cities up and down the country are facing these very same issues, seeking ways to cut costs in the face of increased demand without shifting costs onto other services. That is why, when considering the impact of healthcare on the local economy, we cannot divorce it from a more holistic view of public service delivery. In order to support local labour markets and the wider local economy, health systems therefore need to consider three important reforms: a shift from the reactive to the proactive; holistic healthcare; and integration with other services.

Early intervention

It is an oft-used adage that prevention is better than cure. This applies as much to the health commissioner as it does to the patient. Both early-stage interventions and preventive approaches to health can help to reduce the demand for more intensive, and potentially more expensive secondary care. Early intervention can be used to benefit the labour market much in the same way as it is applied in supporting the health of the public generally: by identifying ill-health trigger points in the labour market and making appropriate interventions.

The health system has known for years the impact that unemployment has on health: increased mortality and higher morbidity; poorer mental and physical health; increased likelihood of long-term illness; and an exposure to more social risk factors. Yet the current healthcare system remains reactive to the ill-health effects of unemployment: treating and responding to poorer health when it presents at a GP surgery or A&E, rather than attempting to reduce the impact of unemployment on health at a much earlier stage.

Sir David Frost and Dame Carol Black's *Independent Review of Sickness Absence* identified how the current health and welfare systems do not adequately support individuals falling into unemployment. The report noted that each year around 300,000 people fall out of work and onto health-related benefits, suggesting that their health condition has been a key factor in their leaving work. However, health issues may go unnoticed or untreated until an individual reaches a crisis point – a trigger for health services to intervene. These trigger points – perhaps a visit to the GP, an increase in severity of the health condition, accessing A&E services – may occur well after an exacerbating factor, such as unemployment, has occurred. Introducing health services earlier, when vital signs occur in the labour market rather than at health-service trigger points, can help to reduce the flow of individuals falling out of work. Labour market triggers could include a sickness absence from work, a claim for benefits, or even a business reporting

potential future redundancies. Shifting resources to intervene at these trigger points can have a significant impact on demand for health services downstream, and also the total cost of welfare as individuals are supported to remain in or return to work.

Pilot schemes across the country have attempted to bring in healthcare at an earlier stage of unemployment. Greater Manchester has already begun to explore how the healthcare system can better support individuals sooner, and help them to remain in employment. One of these initiatives is the Fit For Work pilot scheme, which ran across several areas around the country. The scheme provided wraparound support and a variety of health services for individuals likely to fall out of work and onto health-related benefits. The vital sign for this service to intervene was in reaching four weeks on sickness absence, which in itself is already a relatively late trigger. In Greater Manchester alone, the service supported over 2,300 residents, 96 percent of whom returned to work by the time of discharge. The average cost for the third-year intake to the service – totalling 561 patients – was £436.47 per patient, for an average five weeks of support and three months of post-support tracking. The fiscal saving of using the Fit for Work service in the third year, in terms of the reduction in expected health service costs further downstream, was over £245,000. These figures should speak for themselves.

Proactive interventions aimed at preventing ill health can also help to stem the flow of individuals into more costly and more intensive health support and treatment. Moreover, it can support the local economy: preventing ill health and sickness absence reduces potential costs on employers; it can also improve individual productivity and support long-term business resilience.

The Centre for Mental Health estimated in 2006 that the cost of mental ill health to businesses in the UK was £26 billion a year. Over half of that – £15.1 billion – was as a result of presenteeism, in the form of individuals being less productive than they could be due to a mental health condition. That equates to around £1,000 per employee per year. The centre also estimated that businesses could reduce this cost by around 30 percent, by focusing on early-stage intervention and preventative measures such as utilising the Health & Safety Executive's Stress Management Standards. This is just one example of the potential benefits to business from early-stage and proactive health interventions.

However, businesses need support to implement the right actions at the right time. Unions, health and safety workers and occupational health teams all have a role to play, and health services provide a strong leadership role in supporting these groups. There are many schemes around the country that are supported by local health services and aim to reduce or prevent ill health in the workplace. Through initiatives such as the Workplace Wellbeing

Charter, public health services especially can begin to support more early-stage health interventions, provided by businesses and employee organisations, to prevent ill health among their staff. This can help to create a more resilient system where workers can spring back quickly from ill health and continue to live healthy, productive lives. The benefit to businesses in engaging with such initiatives comes in retaining valuable employees and reducing the costs of ill health.

A wider perspective

To deliver earlier-stage and more proactive health interventions, health services will need to take a wider view of appropriate interventions – in terms of which interventions can have the best impact, and in terms of who is best placed to deliver these services. To be more effective, health services need to understand and accept a more holistic view of health – not just of the various root causes of ill health, but also of the potential solutions. This full-system approach is the only way to deal with complex issues of dependency on public services.

To take one example, many respiratory conditions can be greatly influenced by housing quality; and yet the choice of housing is considerably determined by income and employment. A GP may be able to treat an individual's respiratory infection; yet without a significant change in employment status or income, the likelihood of a change in the quality of accommodation is relatively low. The root cause or exacerbating factor of the condition is not being dealt with, and the GP is therefore likely to see the individual repeatedly. Not only does this affect the employability of the individual (in a vicious circle) but it also adds cost into the system in terms of wasted GP time and capacity, as well as expenditure for treatment and medication.

A more holistic approach would be to offer any number of non-medical solutions to the respiratory condition, with major considerations being the employment status of the individual and the housing offer in the local area. Other options for a mixed medical and non-medical model would – and should – include consideration of the general health and well-being of the individual, and the factors that affect this: relationships, financial issues and debt support, childcare. Moreover, if we expand upon this principle, a holistic view of the health of an individual can also be affected by the employment status of other members of the household, especially the household's chief income earner. As the root causes of ill health may lie in a social rather than medical setting, it follows that a range of social and other non-medical solutions can help prevent ill health or support good health.

This is a much more difficult approach, as it requires an entire cultural shift away from pursuing a medical approach to one where non-medical solutions may be required. Evidence

shows us that being in work, especially good work, can aid recovery, and employment is linked closely with lower levels of mortality and morbidity. Therefore, a focus on supporting individuals with health conditions to enter and remain in work should become a key component of a holistic health service – and a success measure. One of the biggest changes the healthcare system can make to support individuals in work is for any contact point to use their short assessment window to ask a simple question: are you in work? Choosing the appropriate medical and non-medical mix of support can have a greater impact on the individual's long-term health and employment prospects than would a non-integrated approach.

We can take mental health services as a prime example. The majority of individuals with a mental health condition usually require fairly low levels of support; yet the balance of mental health expenditure errs on the side of beds, medication and intensive treatments for those with more severe conditions. Among health-related benefit claimants, just under half have a mental health condition – close to double the prevalence in society generally. Without appropriate support to treat mental ill health at an early stage and support individuals back to work, these benefit claimants are likely to remain out of work, potentially escalating a mental health condition to requiring higher-level and more costly care. This makes it all the more important to commission early-stage, lower-level services for this group, aimed at providing the right level of care at the right time. Low-level mental health conditions may predominantly be caused or exacerbated by social factors. As a result, a wider range of solutions – beyond the traditional use of IAPT¹ – need to be commissioned. This could include such non-medical interventions as peer support, group sessions and community resilience courses.

Through taking this approach, commissioners can better support patients to return to or remain in work. And as we know, work offers much more than income – it can provide social engagement, reduce social isolation, provide structure to a day and at the very least give people something to help take their minds off other issues. Work can therefore be both a means to, and an end of, better health.

Bringing services together

None of the strategies listed above – proactive and early-stage interventions; commissioning a wider range of non-medical services; identifying early-stage interventions for the labour market – can be implemented in isolation. As discussed above, a key criticism of public services is that they are funded in silos, yet the overall impact of each service can influence

¹ IAPT services traditionally deliver cognitive behavioural therapy-based interventions. Yet current evidence suggests that this approach does not work for all people, and that a wider variety of health interventions are required.

costs for other public services. The siloed funding approach leads to a siloed view of responsibilities, not recognising that all services are in reality interdependent.

While funding and outcome measures may suggest otherwise, the responsibility for the health of an individual does not rest with health services alone. Nor does the responsibility for supporting unemployed individuals back to work rest solely with our employment support systems. Both the costs of failure and the benefits of success for public services are experienced across the economy – and especially by the individual. A better-integrated system is required so that public services can jointly reduce costs and jointly support the local economy.

Both co-ordination and integration are required to support individuals who have fallen out of work because of sickness, and to commission a wider range of services for benefit claimants with mental health conditions. To support the labour market, health services need to work more closely with employment support services. There are many obstacles to overcome, though. How do we make these two systems – systems that are funded separately and not designed to interact – work together?

On one side, the health system is focused on providing a medical route to deal with health issues, and on improving or maintaining health. It is a system in which inputs are commissioned. On the other side is a system paid on outcomes: getting people into work and supporting them to remain employed.

While there are certainly differences in the anticipated outcomes from service delivery, these differences are neither incompatible nor insurmountable. Indeed, the outcomes are mutually supportive. It is often in the technical aspects of joining up services that issues arise. For example, if we recognise that work can be an enabler of good health, could we not match job vacancy information with medical and GP records to provide a holistic health and work service? To progress closer joint working between systems, what is needed is a method of commissioning the services together, with emphasis placed on the joint outcomes of improved health and increased employment. By doing this, commissioners can incentivise the design and delivery of better joint-working practices that support the local economy.

Authorities in many areas across the country are looking at new ways of co-commissioning and joint working. Newham IAPT services, for example, are working more closely with employment support providers on referring clients through to appropriate services. Recognising that individuals in recovery often use employment as a recovery mechanism, alcohol and drugs services have long worked with employment support services, and have

developed joint-working protocols as a result. And Greater Manchester's Working Well service, which offers wraparound health and well-being services to health-related benefit claimants, was co-designed by local and national services.

Yet in order to have true service integration, resources need to be pooled at the very start. Subsequent commissioning from this single budget needs to be based on early-stage, holistic and integrated support. By pooling resources, commissioners can begin to widen the perspectives on current public service delivery and remove barriers to delivering better-quality public services. Community budgets, which seek to pool these resources, along with devolved responsibilities to local areas, are the tools by which these changes can be enacted. These tools can support better local management, flexibility in arrangements and funding, and reduced overall expenditure. The end results are obvious: a better service designed around the needs of the individual, a more productive workforce, and all delivered at a lower cost.

To the future

Healthcare is not provided simply for the sake of better health. It is provided so that individuals have the capacity and capability to make the choices they wish to make. Employment provides us with improved life chances, prosperity and well-being – all factors that are supportive of good health. To deliver better-quality healthcare is, by its very nature, supportive of the local labour market, ensuring people can enter and remain in work.

Healthcare in the UK faces the strong pressures of delivering against increased demand while reducing overall cost. This is not an easy task. But in order to best support our workforce, in order to best support our residents, the UK will need to enable a significant cultural shift. Current budgets will need to shift towards commissioning more effective early-stage and proactive health interventions, in order to reduce demand. A wider array of solutions to health conditions will need to be considered, including from areas of the public sector other than health – especially services dealing with social factors such as childcare, debt and housing support. And finally, all public services need to begin to reform how services are funded and commissioned so that true service integration – providing holistic, whole-person care – can be delivered.

Greater Manchester may just be taking the first few steps in this area. But it is also paving the way for others to follow.

Regional dimensions to health, obesity and alcohol consumption

Health inequalities have a clear social gradient. Poorer people die younger and live their shorter lives suffering from more ill health than their wealthier counterparts. The links between deprivation and poor health are well established and have been understood for some time¹ and, as Michael Marmot has emphasised, should be the focus of healthcare.²

The post-industrialised regions of the UK are, therefore, characterised not only by adverse social and economic conditions, but also by poorer health profiles in their populations than wealthier parts of the country – particularly the South East. Health problems such as obesity and alcohol consumption levels are higher in the North than in the South, as are levels of non-communicable diseases associated with these issues.

Over the past decade a number of studies have questioned the extent to which regional variations in health can be attributed exclusively to socioeconomic factors, or perhaps more accurately the sum of the socioeconomic profile of their inhabitants. This chapter suggests that in addition to individual socioeconomic status, where you live has a supplementary impact on the opportunities that life presents to take healthy or unhealthy lifestyle choices, particularly through the life-transforming stage of adolescence, due to variation in the background wealth of regions. Moreover, the way in which cities of post-industrialised regions have been regenerated and reinvented in the wake of neo-liberal restructuring is further implicated in poorer health profiles. In essence these issues amplify the health impacts of poorer socioeconomic status for those living in poorer regions.

Regional health

Poorer regions of the UK, for example the North of England and Wales, exhibit worse health profiles than should otherwise be the case based on deprivation measures alone. The issue is most starkly illustrated by West Central Scotland (WCS), the region with the poorest health profile in the country. The phenomenon, often referred to by commentators as the "Glasgow Effect", means that Glasgow's populace suffer far higher rates of serious disease and premature death than they should; in fact, deprivation alone accounts for less than half of Glasgow's mortality gap with wealthier areas in the UK.³

1 Beale, N "Unequal to the Task: Deprivation, Health and UK General Practice at the Millennium" in *British Journal of General Practice* no 51 (2001), pp478-85; Dorling, D "Unemployment and Health" in *BMJ* no 338 (2009), p829

2 Marmot, M *Fairer Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*, the Marmot review (Marmot Review/University College London, 2010) (www.ucl.ac.uk/marmotreview)

3 Taulbut, M, Walsh, D, Parcell, S, Hartmann, A, Porier, G, Stniskova, D, Daniels, G and Hanlon, P "What Can Ecological Data Tell Us about Reasons for Divergence in Health Status between West Central Scotland and Other Regions of Post-industrial Europe?" in *Public Health* no 127 (2013), pp153-163

Why WCS/Glasgow has such high mortality has taxed researchers. The most comprehensive study investigated no fewer than 17 hypotheses. This work concluded that the explanation that had most currency was what the authors termed the "political attack" hypothesis.⁴ The crux of this argument is that the damaging effects of neo-liberal reform from the 1980s were felt more acutely in Scotland than in other areas of the UK. This was a result of factors such as the high proportion of council housing and industrial employment – early targets of the "political attack" – and the consequence was changes in behavioural patterns in communities that led to negative health outcomes. This study also commented, however, that *all* former industrial areas in the UK had suffered much more in relative terms than, for example, European counterparts, where although neo-liberal policies were also adopted they were more socially inclusive and less far-reaching than in the UK. To some extent all post-industrial regions display worse health profiles than they otherwise might – although the exact mechanisms behind this phenomenon are still open to debate.

Other commentators have also suggested a "London Effect" that is the complete inverse of the situation of WCS. In other words, the health profile of Londoners is significantly better than deprivation levels would suggest. Caution is advised, since the measures of deprivation used in the study on which this assertion is based were not ideal,⁵ but one conclusion was that "close proximity to the least deprived regions of England" might be a key influence.⁶

Obesity and alcohol consumption

Levels of obesity and harmful alcohol consumption follow similar patterns to other health issues in the UK. Generally obesity levels are higher and a greater proportion of individuals suffer the harmful effects of excessive alcohol consumption in Northern regions than in the South East. In relation to obesity the regional differences are not explained by deprivation, or educational achievement, and worryingly the North-South gap appears to be widening.⁷ In terms of alcohol, Local Alcohol Profiles for England,⁸ which tracks a number of indicators such as alcohol-related mortality and hospital admissions, shows clearly that Northern regions fare far worse than the South East. The North East has the highest proportion of people who regularly exceed recommended alcohol limits (68 percent of men and 60 percent of women),

4 McCartney, G, Collins, C, Walsh, D and Batty, D *Accounting for Scotlands Excess Mortality: Towards a Synthesis* (2011), p57

5 The Carstairs deprivation scores included the proportion of households not owning a car – a measure not suited to London.

6 Whynes, DK "Deprivation and Self-reported Health: Are There 'Scottish Effects' in England and Wales?" in *Journal of Public Health* no 31(1) (2008), p151

7 Scarborough, P and Allender, A "The North-South Gap in Overweight and Obesity in England" in *British Journal of Nutrition* no 100 (2008), pp677-684

8 www.lape.org.uk

and the average number of units consumed on the heaviest drinking day in the North East is 9.3 for men and 6.5 for women – exceeding guidelines by more than twice. The average number of units is lowest in London – 6.4 for men and 4.2 for women. Again, the differences are not explained by individual wealth, or educational achievement.

Young people's leisure activities: a case study

Over the past few years the author has been involved in research that has explored young people's health – their physical activity, food and alcohol consumption – looking at these issues from a built environment perspective. One study, for example, compared young people's leisure time and alcohol consumption in the North East and the South East of England.⁹ This research sought to investigate in what ways the lives of ordinary young people, aged 15-16 and living in typical suburban settings that might be found in urban areas in the UK, might be influenced by where they lived. The study avoided extremes of deprivation and wealth, and young people from areas with similar, mid-range scores on the Indices of Multiple Deprivation were recruited for participation. Participants in the study filled in a weekend diary, which was designed to include but not overemphasise alcohol consumption, and were then invited to an individual or small, friendship-based group interview.

In terms of overall attitudes and early experiences involving drinking alcohol, there were more similarities between the groups than differences. The context of the first alcoholic drink was most often a family celebration, such as Christmas, a wedding or a birthday, the amount small (for example, one alcopop), and parental attitudes were similar in both locales. More transgressive behaviour, such as experimenting with friends, teenage parties and drinking in the park, were also relatively similar in both locations. There was some evidence that public, outdoor drinking was more widespread and visible in the North East, with reports of "desperate" adults drinking in parks, particularly after dark. However, in both locations young people generally disapproved of drinking on the streets and in parks, commenting that it was "chavvy". Furthermore, in neither location was there significant evidence of underage drinking in licensed premises.

There were, however, key differences between the overall experiences during leisure time of the two groups. Young people have a lot of spare leisure time to fill. Research has shown that the presence of nearby leisure facilities correlates with increased levels of physical activity, healthier diet and healthier weight status in young people. Furthermore, the role of organised activities (such as those involving sports and music, or youth clubs) has also been highlighted as a way of both delaying the start of alcohol

9 Roberts, M, Townshend, T, Pappalepore, I, Eldridge, A and Mulyawan, B *Local Variations in Youth Drinking Practices* (Joseph Rowntree Foundation, 2012); Townshend, TG "Youth, Alcohol and Place-Based Leisure Behaviours: A Study of Two Locations in England" in *Social Science and Medicine* no 91 (2013), pp153-161

consumption and/or reducing amounts drunk.¹⁰ This was supported by our study: for example, young people commented that they did not want to arrive at organised events feeling hung over, or risk letting team mates down with a poor performance during activities. Significant to this was that the activities cited in the young people's diaries (and subsequently discussed in the interviews) were far greater in number and far more varied in the South East than in the North East. Furthermore the percentage of young people involved with organised activities, for example visiting youth clubs or participating in sports, was much higher in the South East.

It must be stressed that this was not about individual wealth. In fact, there was no relationship between individual disposable wealth and engagement in activities. Even activities that were ostensibly free, such as visiting a local park, were more frequent in the South East. Furthermore, when the interviewees in the North East were asked what would improve the places they lived, they responded by citing the kinds of facilities – a space to play football, a nearby skate park, access to a youth club open at the weekend, an ice-skating rink – that were easily accessed by young people in the South East.

The most significant difference between the two groups of young people was in the opportunities that the places they lived offered them in their everyday lives; in particular, the opportunity to access new possibilities and positive influences. Again, this is not about greater affluence of individual households in the South East. This is the about the greater *investment, supply* and *quality* of public and quasi-public amenities in the South East, including those particularly targeted at young people, such as youth clubs and age-targeted facilities in parks. Moreover, that difference was amplified in many ways – an example of this would be the public school in the South East that opened up its state-of-the-art sports facilities for local schoolchildren during vacation time – similar opportunities did exist in the North East, but were relatively expensive.

Other facilities were often inadequate or less accessible in the North East; for example, swimming at a leisure pool in the North East was more expensive and difficult to visit than an equivalent facility in the South East. In the North East a group of BMX enthusiasts bemoaned the fact that there was only a single provision of stunt/skate park, which they were not even able to access as it was too far to cycle and they were not allowed to take their bikes on the local public transport. By contrast, one of the South East housing estates (similar to the one in which the North East participants lived) had three skate parks within a mile radius.

Moreover, broader physical and culture settings came into play. For example, the most popular cinema for young people in the North East study area was built as part of an indoor

¹⁰ Velleman, R *How Do Children and Young People Learn about Alcohol: A Major Review of the Literature for the Joseph Rowntree Foundation* (Joseph Rowntree Foundation, 2009)

complex that had originally been intended to be an exclusive shopping centre. The weak economy of the region means that retail is extremely location-sensitive – basically, anything outside well-established retail space struggles to survive. No retailers came forward to occupy the empty units, so the council (albeit reluctantly) allowed them to be turned into bars and clubs. Consequently, young people going to a film at 6pm on a Friday or Saturday (not unreasonable at age 15-16) emerge two hours later amid the clamour of nine chain-style bars, which must be passed before exiting the complex. By this time they are already packed with adults, most of whom will be consuming alcohol, and some of whom will be showing clear signs of excessive consumption.

The superior offer of provision to young people in the South East not only provided them with the opportunity to mix in a wider social setting and learn new life skills, thereby enhancing their self-esteem and generating a sense of achievement, but it also did so in a context separated from adult alcohol-related leisure. When the young people in the two locations were asked what significant change would happen to them when they turned 18, those in the South East talked about learning to drive, going away to university or finding their first job. Young people in the North East talked almost exclusively about being able to go out drinking with friends in the city centre.

The above findings were echoed by other work exploring young people's lives in terms of physical activity and food consumption – particularly in relation to the lack of basic opportunities for exercise and non-alcohol-focused leisure.

Discussion

Lifestyle behaviours and problems formed in childhood and adolescence tend to track through into adulthood – obesity and excessive alcohol consumption have very clear life-stage trajectories. Moreover, positive lifestyle habits are mutually reinforcing: people who have more interests and a positive outlook on life take more exercise, eat a healthier diet, drink alcohol more moderately and so on. I would argue, therefore, that you can extrapolate from the findings of the young people's study above to the wider community and to more generalised principles that relate to both the "London Effect" and "political attack" hypotheses covered earlier.

People in London suffer less ill health than their individual deprivation levels would predict in part because they are surrounded by an almost inexhaustible variety of opportunities that may lead to life-enriching experiences and thereby improved health and well-being. People in poorer Northern regions suffer more than their individual deprivation levels would predict because those opportunities are often inadequate, or entirely absent. Moreover, in Northern cities – desperate for investment after deindustrialisation – physical

regeneration in city centres has provided a context for a normalised monocultural (young) adult life focused on alcohol-related nightlife, which is unhealthy in multiple respects.

The limitations placed on people's lives in poorer regions mean that across whole communities people have a lower health and well-being potential than those in the richer South. Unless this inequality is addressed, it is likely to contribute to a widening health gap into the foreseeable future.

Age-friendly city – Newcastle, ready for action

Since the launch of the WHO's Global Network of Age-friendly Cities, a number of towns and cities have been attempting to support their increasing ageing population through action, often on transport, leisure activities, and housing choices intended to promote staying active and connected in later life. In this chapter we explore how Newcastle is attempting to reshape itself to meet the challenge of ageing.

Newcastle's premise is that just as health and well-being are created in the context of everyday life rather than in interactions with health providers, so the ability of older people to make positive choices in their daily lives is what maintains a flourishing old age. This leads to an understanding of the critical role of place in underpinning resilience, so that individuals can care for themselves as well as for relatives, friends and neighbours. Responsibility for creating quality places in which to live and age well becomes a shared concern, with local government, private-sector actors, the third sector and communities all having a role to play.

National and local trends

The UK is officially a mature society: one in which the proportion of over-60s is greater than that of under-16s. The shift in the balance of the population from younger to older is happening more quickly in the North East than in any other region; however, the experience of ageing is not uniform. In Newcastle men and women have, on average, shorter lives than those in more affluent parts of Britain, and both men and women will spend more of their shorter lives contending with disability and activity-limiting illness. There are great inequalities, such that in exploring disability-free life expectancy, the Slope Index of Inequality shows a 16.5-year difference between men in the most and least disadvantaged city wards, while for women this is 13.3 years.

It is clear that quality of life in later life is determined by the accumulation of positive and negative effects on health and well-being throughout life. This understanding has broadened the city's overarching aim to enhance quality of life not only for older people, as has been the goal for many other cities in the age-friendly network, but for people at all stages of the life course. It is only through this life-course approach that we ensure that more people age well.

While city-based older people's organisations had been working for more than a decade, making small wins, it was the cross-party commitment made by the city council in signing up to the Dublin declaration¹ in autumn 2011 that made possible transformative change. Newcastle now has a vision of itself as a world leader in creating a city where people

¹ The signing was the culmination of a meeting in Dublin, which was the World Health Organisation's first international conference on age-friendly cities.

live their lives to the fullest potential and age well. This commitment has broadened and deepened, signalled by the shift of monitoring responsibility from the council's adult social care directorate to the deputy leader's office.

The aims are ambitious. We want to go beyond simply adding older people into the existing mix. Our vision is of a city transformed that takes account of the changing age profile when planning for the future; takes an asset-based approach to the role of older people in the city; and removes the indignity and dependency from some people's experience of old age. How can this be achieved in a city labouring under severe spending cuts that affect services for all groups, including older people?

Working for change through the age-friendly city partnership

The need to make comprehensive changes to the city's offer demands a partnership-based approach. In Newcastle this draws to the table Newcastle and Northumbria universities; the local enterprise partnership; the chamber of commerce; nationally networked planners and architects; Age UK; the local clinical commissioning group; and Newcastle's Quality of Life Partnership. This last provides co-ordination of the age-friendly city initiative under the direction of the city council's political leadership. Importantly it also acts as a conduit for the voice of the Elders Council of Newcastle and works to include the views of older people in the city's less advantaged neighbourhoods.

In bringing together such a broad group, it is critical that all partners understand each other's roles, responsibilities and constraints. While in many policy areas the role of the local authority has changed from provider to enabler, its role in the age-friendly city (AFC) initiative is to provide leadership delivered through policy direction. The planning directorate has debated the wording of a policy thread for the core strategy that could unequivocally set out the city's vision to developers. Housing and adult services departments have reached a shared understanding that the historical lack of a life-course approach has resulted in trajectories that often lead to dependency in older age. They now share a determination to deliver alternatives across the life course and across the social gradient, in order to change this pattern. This becomes a strategy for the city to adopt a social model of public health, and to emphasise prevention and interventions based on information sharing and tele-care options available for all. Meanwhile, for those in need of higher-level support, new models are being developed that deliver choices and rights to vulnerable elders.

There are many challenges. Not just new ideas but new processes are demanded. The first stage of Newcastle AFC has been working to bring new voices into our "big conversation" by reframing ideas and challenging diverse city actors to approach the

issue of ageing in new ways. Funded research led by Newcastle University allows the possibility to work with local people, seen as citizen sense-makers, to develop a shared understanding of the experience of being in the city. There are key roles to be played by citizens, and various actors are scoping out variations on the "urban room" – a middle space where designers, "knowledge experts" and "citizen experts" can imagine together and co-create new solutions. The challenge is to fuse these conversations so that those with ideas and those with funds can make this happen.

Priority areas for action

There are three main policy action areas: the role of ageing in the local economy; the need to reshape the physical and social infrastructure of our city; and the need for greater choice in housing.

Greying region = economic stagnation?

An asset-based approach to older people reveals they are economic contributors. As carers of adults they provide an informal contribution of £11.4 billion, as well as providing £6.6 billion of childcare and £5.8 billion of volunteering. In Newcastle half of all unpaid care is given by those aged over 50, and one third of those providing 50 hours or more of unpaid care per week are over 65 years of age. These in-kind societal contributions are perhaps the ones traditionally expected. What is different is the increasing participation of older people in the labour market, as the concept of a fixed retirement age blurs.

As workers, the over-65s currently contribute £37 billion to the national economy. The 2013 *Aviva Real Retirement Report* highlighted how much the face of the workforce will change, in reporting that one in four of those aged 65-74 continue to earn a wage and that one in three over-55s plan to work part-time in retirement. Senior entrepreneurship is at its highest level, with nationally 600,000 people aged 50-plus engaged in some early-stage entrepreneurial activity.

It is clear that as both the nature of work and society change, the mental capital of older people could be much better utilised to enhance their quality of life and to benefit the economy directly and indirectly. This is an unprecedented challenge and one that seems to be ignored by recent reports, including the Lord Adonis report on the North East economy.² Negative stereotypes of older workers still impede progress, as does the view that employers simply need to add on an "older worker policy". The city-based company Age Inclusive is working with employers and trade unions

² *North East Independent Economic Review* (2013), commissioned by the North East Local Economic Partnership

to understand the implications of an ageing workforce that demands a life-course approach to retention through job redesign, remodelling of workplaces and flexible practices. A major challenge for our region is promoting opportunities for re-skilling and retraining across the workforce, including manual workers, so that fewer enter retirement from unemployment. This has to compete with the political concern for young people not in education or training.

While wealth inequalities are wide, nevertheless people over 50 are responsible for about 40 percent of consumer spend. One of the uphill struggles has been persuading retailers and service providers of the spending power of the older customer. The demographic shift also stimulates opportunities for new products. Newcastle University, supported by the European Regional Development Fund, is engaging with companies to help them develop ideas and grow their business in this emerging market.

The university, through its research in digital interaction, is exploring how people can be supported to live in their own homes longer through existing technologies used in new ways, as well as developing new systems. This not only impacts on quality of life but is a catalyst for new business opportunities.

A reality check on who has money to spend provides some tough choices for Newcastle, which in looking to fashion a new, post-industrial identity has succeeded in building a global reputation as a party city. Everyone can go to a party, but it is clear that the target market is the under-30s, whose spend (according to national figures) on recreation and culture is a mere £44.70 per week, compared with the £147.40 spent by the over-50s. Similarly, the under-30s spend on hotels and restaurants only half of the £76.60 per week spent by the over-50s.

As a city we need to capitalise on our broader cultural offer, as reflected in our fine architecture, art galleries, concert halls, restaurants, retail and access to high-quality natural environments. The challenge is how to maximise the city's share of the older city tourist and to improve the experience of the city for its own older people, without stopping the party. While the health consequences of an alcohol-based night-time economy may be painfully clear, this brings a lot of money into Newcastle that supports business and jobs.

The fabric of the city: isn't it just about seats and public loos?

What should our city look like? Earlier visions of age-friendly cities looked to disability models, placing a value on inclusive design that can make cities more welcoming to people with disabilities, parents with young children and the less mobile. There are

opportunities now to make more radical changes, if we have the courage. Recent reports on retail trends suggest that the high street, as we know it, is probably redundant. The big superstore where everything can be bought at any time, coupled with shop-and-drop services and e-commerce, have transformed British shopping habits.

This provides opportunities for making new choices. Since the recession, many retailers have retreated to the small, inner core of shopping streets. Beyond this buoyant zone, there is an area of churning businesses. Why not remodel a group of empty shop units into multi-generational housing? Previous action taken under the Living over the Shop initiative has proved that increasing the residential element creates increased demand for city-centre services. Why not insert pocket parks, crèches, learning spaces, clinics? The RIBA's *Silver Linings* report³ provides inspiration for new approaches, though there is little prospect of local change in the short term.

There are different challenges in small places. If high-quality places are critical in supporting a good later life, the neighbourhood and the dwelling may play the most important roles of all. It is, and will always be, important that frailer older people can conduct their own affairs within easy reach of their home, in what is called the "20-minute neighbourhood". Securing local shopping parades is a challenge, and city council services such as libraries are often anchors for small retailers. Protecting much-needed local services in the face of public austerity has led to partnerships with local colleges and residents' associations, with the aim of retaining and maximising the local offer and bringing local voices into decision making and management.

Through the city council's digital inclusion strategy and IT support taking place through inter-generational skills transfer sessions,⁴ many older people may stay connected by making more of their technology and take advantage of opportunities such as telemedicine. The convenience needs to be weighed against the social interaction and activity opportunities that neighbourhood services provide. What about new ways of bringing people together? Is the neighbourhood the place for a community garden or orchard with sales space or café? Or perhaps a pop-up university in the local pub where people can engage with MOOCs (massive online open courses) in a group learning environment?

One of the aims of the AFC is to understand the lived experience of ageing in different neighbourhoods, in order to make best possible use of reduced budgets for elder care

3 Parkinson, J, Hunter, W and Barac, M *Silver Linings: The Active Third Age and the City* (RIBA, 2013)

4 Northumbria University Student Union set up open IT sessions for older people in 2014, for which it won an "I Made a Difference Award".

and the once-thriving city third sector. The aim is not to take one snapshot but to maintain dialogue, so that as the age profile changes in neighbourhoods there can be appropriate responses. Participatory research using storytelling and drama, in adjacent and typical Newcastle wards, reveals older people celebrating their own resilience and their local support networks of friends, neighbours and community groups. The challenge is how to underpin these networks in acceptable ways as people age and needs potentially become greater than local resources can manage.

Housing: doesn't everyone want a bungalow?

It is well known that housing can underpin or undermine health and well-being. For older people, it has the potential to promote independence and reduce demand on health and social care services. Research suggests that there are too few specialist housing units to meet demand and that, in spite of more people ageing well, there will be a need for supported living – particularly for those with dementia that cannot be managed at home. The AFC's concerns lie with traditional models such as sheltered housing: is this housing that older people aspire to? Does poverty of choice explain why few people move in later life?

Through the Quality of Life Partnership, older people have long been expressing their dissatisfaction with both social housing and private developers' understanding of later life as a time of narrowed horizons that can be contained in small units of accommodation. New concepts of later life as a time of new beginnings rather than endings demands a different approach to housing design. Workshops with older people suggest a breadth of preferences: potential downsizers who want fewer rooms but large spaces; the culture lovers who want the high-quality city-centre apartment; the would-be co-housing dwellers who want to be involved in the search for better solutions, including strong involvement in design and thereafter in models of living and management based on reciprocity. Given that many older people have housing assets and need no finance, these are, or could be, profitable times for housing providers. How do new ideas enter the development industry? Who needs to hear our findings so that they may be agents of change? This is our current preoccupation.

Whether Newcastle can break through into action is still uncertain. In theory, hard times breed innovation and creative thinking, but the reality is that this is interpreted by many actors as carrying risk, and the concept of age-friendliness becomes one of a range of competing objectives. If economic growth is the key priority for our city and region, then it is delivering clearly the message that older people may be an engine for that growth that will generate real commitment and change on all our priority issues.

London health and growth – a challenge for governance

London ranks among the world's truly great global cities. It has a vibrant, diverse and growing population, houses some of the finest health and academic institutions, and has a strong and innovative local government sector. Of course there are challenges – its health inequalities are well documented, and the current funding pressures will require transformative solutions and radically more integrated cross-sector working. But the talent and will are there. The challenge then is to address the factors that could inhibit the necessary pace of change.

The "London is different" argument can generally be guaranteed to irk all non-Londoners, but it does not make the assertion any less true. Its relevance in the context of this chapter is in the sheer complexity of relationship management and difficulties in partnership working where organisational accountabilities are ill-aligned geographically and the population served is highly mobile.

Start with three tiers of government: the 32 boroughs, each complete with its own health and well-being board (HWB) and overview and scrutiny committee (OSC), plus the City of London, the Greater London Authority (GLA) with its mayor and assembly, and then Westminster with its nationally held responsibilities. Link this into health via the clinical commissioning groups (CCGs), which largely mirror the borough boundaries, thus giving them small (by NHS standards) population bases on which to commission health outcomes; add 20-odd acute trusts (some foundation trusts, some not), which are collectively responsible for a large number of individual hospitals (equating roughly to one per borough); acknowledge the dominant role of the major teaching hospitals in relation to tertiary services, research and training; augment with several single-speciality hospitals, the mental health and community health trusts – not to mention the emerging consortia of GP practices as providers – and you get a sense of the complexity. And that is before you add in education institutions, now much better connected via the academic health science centres (AHSCs) and their associated networks, private and third-sector providers, and the plethora of institutes and quangos that all have a role to play.

Every time any of these systems reorganises, or holds elections, London's organisational memory is damaged and personal relationships have to be re-established. Little wonder then that the capital can appear inward-looking and fragmented to larger partners (commercial and public-sector) wanting to work at scale and pace. The absence of cross-sector agreement around a strategic vision leads to chronic short-termism and endless reinventing of the wheel.

The health service and local government are two of the great pillars of public-sector delivery in the capital, but historically they have operated in separate silos, each struggling to understand how to get the best out of the other for the benefit of Londoners. Key issues that have traditionally constrained them from optimising the potential that exists include:

- limited understanding of the opportunities and challenges of the other's sector, coupled with insufficient recognition of the very strong but very different culture of each;
- the lack of effective engagement with the population as a whole;
- the absence of an accepted pan-London forum where all accountable partners could co-create a strategy for health and well-being outcomes as well as for wealth creation.

Most NHS leaders have worked in the service all their professional lives. They speak in a shorthand peppered with acronyms and incorporating assumptions that are simply incomprehensible to the world at large (think why NHS non-executive directors say it takes so long to become effective). Conversations on health matters with elected members, who will come from all walks of life and for whom health may represent only a small part of their responsibilities, frequently assume an unrealistic level of knowledge.

The reality of the difficult financial challenges faced by each sector is poorly understood by the other, and both feel that their world is the tougher one – a mind-set not conducive to solid partnership working and financial risk sharing. The legal requirements on local government to set a balanced budget impose considerably more discipline than comparable NHS arrangements, where top-slicing and general shifting of goalposts are not infrequent occurrences. In that context the recent diversion of some of the Better Care Fund into hospitals may not have surprised NHS colleagues but was an unwelcomed and unexpected wake-up call for local authorities.

It is worth reflecting on why, despite the need for greater integration, local authority presence (and particularly that of elected members) is minimal at events such as the excellent King's Fund programmes when health and well-being policy is being debated.

The most toxic interactions generally relate to major service reconfigurations. Health colleagues might usefully compare the NHS's approach to engaging with politicians to how they might feel if attending a Ministry of Defence briefing on Afghanistan. One might manage most of the acronyms and understand what troop deployment is planned, but if aggressively door-stepped by the media on leaving the meeting and asked to defend the proposed plan most people would buckle because they have inadequate context to do otherwise. (And that's before adding in the extra pressure created by an unsupportive public who expect their elected representatives to represent their concerns.)

It has always been difficult to suggest a service is becoming unsafe, without rocking public confidence. But the alternative – a service that was apparently safe yesterday and is now so dangerous it must be closed immediately – lacks credibility. The greater transparency brought about following the Mid Staffs poor-care scandal is a welcome development.

In my experience, politicians across the political spectrum are pretty genuine in their desire to create a better society – even if the public (and the NHS) remain unconvinced on this point. However, just as not all doctors think alike or have the same responsibilities (a GP is likely to have a different perspective on health spending priorities than a hospital surgeon), so too politicians' views differ not solely because of party allegiances. For example, the council leader will have a pressing need to see contained the social care costs for which they are accountable; the local MP sees his responsibility as amplifying constituent concerns. The mayor's legal powers on health are very narrow, being restricted to the production of a health inequalities strategy. He has a general platform for standing up for London's interests, but the financial consequences for poor health provision do not fall onto his budget.

It is undoubtedly true that the voice of the mayor will attract media attention. However, there is an unending list of requests for support on a wide range of issues, beyond health. To focus on those things that offer the prospect of some success, it is necessary to be selective. Backing endless lost causes reduces a politician's impact and so makes it harder to be successful with the next campaign request. In addition, commenting on issues that are the legal responsibility of either national government or the boroughs can only be done judiciously. Both will rightly defend their democratic legitimacy to take such decisions without unsolicited interference.

In addition, all elected politicians are wary of accusations of implementing a "nanny state". While the public are generally unoffended by their GP telling them to stop smoking and the like, even if they have no intention of following the advice, the same is not true of advice from politicians. Elected members will have rung the door bells, cap in hand, soliciting support for an election manifesto that you can guarantee will not have included pledges to enforce a different lifestyle on those who have just voted for them. Attempts to do so will have the politician lampooned in the media.

A more nuanced approach that correctly identifies which tier of government has most to lose if the issue is not addressed, and then considers what powers that entity can actually bring to bear, is most likely to be successful. The ban on alcohol on the Tube is a classic case where the mayor was concerned about the impact of drunkenness on fellow travellers, actually had the powers to impose the ban, and was therefore willing to shrug off criticism from libertarian opponents.

Most NHS leaders' exposure to politicians is based on appearing before the local OSC: not always a satisfactory experience. In addition there is sometimes a lack of awareness that, just as in parliament, the council leader needs to manage the internal dynamics of his own group and that the OSC chair may have no prior knowledge of, or interest in, health matters, nor may he enjoy the ear of the leader.

Local government is altogether more pragmatic, and the normal cut and thrust of the council chamber is often distinctly unsettling for those not used to it. The NHS, by contrast, is evidence-based and technocratic in its approach. Its strong tradition of top-down command and control is reinforced through the NHS accountable officer regime. The fact that NHS chairs are not executive chairs, and have no formal authority other than through their board, creates a further mismatch, as council leaders often see chairs as their natural counterpart.

None of these issues is insuperable, but all require the investment of time and energy on both sides to get the best from the other.

Londoners themselves would be a much stronger force for good, and indeed might demand support of their politicians, if there were greater transparency on the unacceptable variability in health outcomes and more clarity on what "good" looks like. The public debate needs to move from "defending cuts and bricks and mortar" to demanding high-quality outcomes.

The historical ban imposed by the NHS on anything that smacks of marketing is misguided. The negative publicity that generally surrounds service reconfiguration (think stroke and trauma consolidation) is never counterbalanced after the event with a media strategy that reminds the public of the very real benefit accrued.

Although the situation is improving, it is still difficult for the public at large to get the kind of information that would make them informed purchasers – especially for care across the whole patient pathway. (The introduction of personalised health budgets may force change, but currently lay users of the health observatories need an appetite for statistics that most simply won't possess.) The unwritten convention that has prevented NHS professionals from publicly criticising performance failings is now being challenged and rightly so, but for too long the public were simply in the dark as to the scale of the quality differential. Consequently consultations have often been reduced to a debate on marginal travel times, with the major issues on clinical outcomes not fully understood or accepted.

The challenge for Londoners today is no longer infectious disease but chronic conditions,

on which better lifestyle choices would reduce prevalence and enable sufferers to exercise more control over their condition. Balancing the temptations of instant gratification against longer-term benefit remains a challenge for us all. Health professionals would do well to enlist the support both of their academic colleagues studying human behaviour and of local authority partners. The former should provide insight into how the public could be better supported and “nudged” in the right direction, while the latter can control (directly or through commissioning) or have influence over (such as through local housing associations) many of the services that have greatest contact with the target groups which health professionals most need to reach.

At a borough level, HWBs are providing a real opportunity for change, especially where senior elected members have provided personal leadership. Silo working is being challenged, cultural differences are being addressed and mutual trust established. Integration of health and social care is generally accepted as the holy grail, though the means by which it is delivered may vary and the poor alignment of financial incentives and difficulties of data exchange present challenges.

Improving health outcomes and tackling health inequalities remain at the core of HWBs’ work, through the production of the joint strategic needs assessment and the joint health and well-being strategy. However, tackling some of these challenges requires action beyond the neat confines of the borough boundaries and powers. In addition, the absence of any provider voice on many boards may prove to be a limiting factor in their success.

What has not yet appeared in a crowded HWB agenda is the recognition of NHS providers as major employers. In truth, there is a tendency for both the NHS itself and the local authority to see the trust simply as a provider of healthcare as opposed to a major economic asset and wealth creator with interests in infrastructure, regeneration and skills shortages. In my own patch we found that engaging the tri-borough leaders and the chief executives of the major employing trusts in a separate event provided a better forum for developing an understanding of each other’s strategies in these key areas and building a sense of common purpose.

When I arrived at City Hall in 2009, biomedicine warranted little more than a single line in the mayor’s economic development strategy. The role of the emerging academic health and science centres and networks (AHSCs and AHSNs) was not fully appreciated, and these groupings themselves seemed ambivalent about having wealth creation as a specific part of their mission. Yet the capital was, and remains, fantastically well placed with both an impressive collection of world-class institutions and an infrastructure to compete globally as a biomedicine hub.

To exploit this fully, however, the three AHSC/AHSNs had to commit to work more collaboratively, which is essential since London's high world ranking on commercialising research comes from considering the capital as a whole. The international agenda was forging ahead, with new global locations emerging. External commercial partners told us that London appeared fragmented and a complex place to do business, and the GLA was keen to offer what support it could to tackle this.

Fast-forward six years, and much has changed. In setting up the LEP, the mayor recognised the importance of ensuring that within its membership there was real understanding of the sector and its potential. The level of ambition behind its commitment to the establishment of MedCity¹ earlier this year is palpable. Its objective of promoting a globally distinctive life sciences offer and serving as a "go to" point for businesses and investors alike, while championing the creation of a more entrepreneurial culture among our researchers, is the manifestation of the AHSC/AHSNs and the GLA and other partners working effectively together. The establishment and publication of key benchmarks to track progress against key global competitors would make this success more visible to the public at large.

More recently the mayor has established an independent inquiry to consider how London's health and healthcare could be improved for the benefit of the population. This is consistent with the powers he actually has – whereas an attempt to unilaterally enforce its conclusions, assuming he was minded to do so, would exceed them. However, the London Health Commission, under the chairmanship of Professor Lord Darzi, is unique in the breadth and seniority of its membership and does offer the realistic possibility of a much-needed high-level vision for the capital to which all partners can subscribe.²

Its focus includes: improving the integration of care, enabling high-quality care, reducing health inequalities, the health economy and wealth creation, and better engagement with the public on health decisions. It will report later this year. Politics (small and capital "P") will need to be managed, but an agreed set of priority themes, together with a focus on health enablers such as systems integration and better real estate utilisation, could offer a real vision for the way forward. Government departments would do well to consider seriously any requests for greater devolution to support this. Equally the boroughs will need the assurance of the possibility of local solutions within a larger agreed framework if they are to endorse the commission's conclusions.

While no single authority has overall control of all the levers that determine good health

¹ The reference to MedCity includes Oxford and Cambridge.

² *London Health Commission: Scope and Call for Evidence* was published on 25 November 2013 by the London mayor.

outcomes and optimisation of wealth creation, a commitment from all those who have a stake in the game to contribute to a common cause would indeed be a cause for celebration.

NHS reorganisation – a story of turbulent governance and changing institutions

Reorganisation

The radical nature of the Health and Social Care Act of 2012 was, notoriously, in stark contrast to its billing prior to the last election as “no top-down reorganisation of the NHS”. With hindsight it seems likely that senior members of the government failed to grasp the scale of the changes implied, despite the signals both in Andrew Lansley’s earlier green paper and in the Liberal Democrat manifesto. Their uncomfortable amalgamation as part of the Coalition agreement is fascinatingly described in the King’s Fund account *Never Again?*² by Nicholas Timmins.

A telling verdict on Andrew Lansley and the process of the reforms, quoted by Timmins, is that of the chief executive of a major private hospital group:

If I went to my board and said that I'd told my senior management that I was merging all their posts before making them redundant in two years' time; that I'd told all my finance people they too will be going; and that I was going to get some other people to run the business; and that while I can't yet define it precisely, it will involve the nurses – well, I think it would be me who was out of a job.

This legacy of administrative change – and expensive change to boot – based upon ideological principle rather than pragmatism continues to have an impact upon the English healthcare system. Indeed, it may be thought remarkable that in the face of such managerial disruption the performance of the NHS has remained relatively robust.

Need and demand

In that last sentence, of course, the operative word is “relatively”. At the time of writing this chapter, accident and emergency waiting times are being reported as the worst in a decade, and 14 hospitals have declared major incidents as a result of unmanageable demand.

General practitioners report continuing escalation of demand in line with the steady rise seen in recent decades. Consultations per person are known to have risen from 3.9 per year in 1995 to 5.3 in 2006, and we have no reason to doubt that trend has continued. The size of the population in older age bands expanded disproportionately, and the greatest proportional increases in consultations have occurred in this group. There are more old people, and they use services more.¹

¹ It is worth noting, incidentally, that this pattern of increased usage argues against calls to charges for GP consultation – the age profile of users means that many or most would be exempt, while those liable to pay would be further driven towards inappropriate or unnecessary use of A&E services.

It is probable, from this perspective, that current difficulties in the NHS are more an expression of long-term trends than of acute change – in keeping with previous observations that culture and front-line practice tend to remain intact despite the “dynamics without change” of structural reorganisation.

Funding

Shifting demography and demand are well recognised as drivers of service cost, and the *NHS Five Year Forward View* envisages a funding mismatch driven by this trend by 2020/21 of £30 billion a year, assuming flat real-terms funding with no further annual efficiencies. It goes on to propose that this gap may be reduced, depending upon the delivery of transformational changes in the interim period.

Compare this with the projections made by Derek Wanless in his reviews of 2002 and 2004. In the Wanless “fully engaged” scenario,² the share of national GDP required for health spend in 2020 was projected as being approximately 10.7 percent, and would have exceeded 10 percent in the early part of this parliament. In contrast, the most recent World Bank estimate of UK health expenditure is 9.4 percent.

NHS net expenditure in England is identified by the NHS Confederation as £113 billion for 2014/15.³ As a proportional shortfall, this would imply that, had the fully engaged scenario been achieved, the NHS in England would already require at least £7 billion more than it currently receives, rising to around £15 billion by 2020.

There is, therefore, a crude equivalence in the Wanless and Stevens assumptions – that, even with maximal engagement and efficient use of healthcare, there is already, and will remain, a shortfall in funding of several billion pounds needed to sustain provision in the face of rising need. Since the country is manifestly short of full engagement in its health, these estimates should properly be considered conservative.

Among other G7 nations, only Italy, which enjoys the well-recognised Mediterranean health advantage, spends a lower proportion of GDP on healthcare.

This financial squeeze is compounded by simultaneous downward pressure on council social care budgets as a result of austerity measures, and by redistribution of funding allocations

² Wanless postulated three theoretical future scenarios for population health, namely: “slow uptake” (no behavioural change, constant or deteriorating health status, unresponsive services, low productivity); “solid progress” (some behavioural change, considerable life expectancy rises, appropriate use of primary care, and efficient resource use); and “fully engaged” (large-scale behaviour change, large life expectancy rises, dramatic health improvement, high-quality care, high rates of disease prevention and service efficiency).

³ <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>

that weigh disproportionately upon deprived areas.

Under the circumstances, it is hardly surprising that the NHS is suffering rising demand, with substantial pressure through emergency admissions, not as an acute phenomenon, but as a manifestation of chronic trends.

Frank Dobson, when health secretary in the first Blair government, was advised to describe the NHS as a "supertanker turning" to emphasise its enormous inertia and seemingly inexorable momentum. The adviser providing those words was Simon Stevens, now the chief executive of the NHS, who must now be reflecting on their prescience.

Cost control

Among health service managers there is a well-recognised truism that money is, essentially, only saved by closing facilities and by reducing staff or staff costs.

In the wake of the Darzi review, some progress had been made at regional level in considering how to rationalise acute-sector provision under clinical leadership – for example, through appropriate configuration of accident and emergency/major trauma units, maternity services, and paediatrics. These efforts died in the renewed drive of the NHS towards more market-oriented approaches – despite strong protests from professional bodies – and with the reinforcement of competitive relationships between NHS trusts.⁴

Under the Health and Social Care Act, regional mechanisms have been stripped away, and NHS England – financially straitened and undergoing yet another reconfiguration – is positioned at a distance from local services. It lacks even the limited leverage of the old strategic health authorities.

Clinical commissioning groups have taken on the roles of primary care trusts but with much lower infrastructure support, and without the mechanisms to properly control acute-sector activity. PCTS were themselves poorly equipped to curb trust behaviours, so it is not surprising that CCGs should struggle with their powerful and politically adept providers.

Since the mechanisms for rational distribution of facilities have been removed, and staff cannot be reduced in number (indeed, electoral approval is sought through sustaining or increasing staff numbers and unquestioning defence of local provision), the remaining avenue for cost-savings is to reduce the income of health service workers in real terms – a policy pursued remorselessly over recent years, and to which any new government appears to be committed.

⁴ Lord Darzi's review, *High Quality Care For All*, was published in 2008, along with guidance on "leading local change" that envisaged a clinically led, quality-focused approach to local strategic planning of services.

The Better Care Fund

Along with short-term injections of cash, aimed at relieving the symptoms rather than the chronic disease of healthcare need and demand, hopes for relief of NHS pressure have been pinned upon the so-called Better Care Fund. This is not new funding, but represents a planned top-slice of existing budgets to pay for action at the interface of acute health service provision and support in the community, postulated to reduce demand upon hospital services.

The evidence base to support this is slim. There is very little, if any, precedent for diminishing demand in this way – particularly in the face of demographic momentum – and it carries with it substantial risks. In essence, it represents a gamble in which the punter assumes his winnings will pay for the stake – a form of pyramid-scheme health economics that will almost certainly lead to doubled running costs. It also assumes motivation on the part of NHS trusts to reduce their income streams, which goes against all of their instincts, past behaviour and future plans.

Moreover, there is a dangerous assumption underlying the thinking behind the Better Care Fund – that integration of care and community substitution for hospital provision are, per se, cheaper than current patterns of provision. In truth, they may be preferable (and certainly desirable) in delivering a better quality of life for those affected, while only shifting costs within the system.

Public health

Amid the controversy of NHS reform, changes to the public health system were a relative oasis of consensus. Very little opposition was voiced to the move of local public health departments to local authorities, and this policy continues to command substantial and widespread support despite significant problems around terms and conditions, training and funding.

At this level, the clustering of health-related behaviours and their interdependence with environment and context can be far better addressed than through more segmented, disease-specific approaches. Moreover, this is the frame in which the centrality of deprivation to ill health is most clearly seen and understood.

Accusations of "raiding the public health budget" by cash-strapped local authorities have been commonplace. Such claims have often been protests against change rather than arguments against the legitimacy of funding choices, but in the context of financial hardship the potential for substitution of local authority revenue funding remains real.

This is a shame, since public health at local authority level is beginning to play out a substantial and important debate about the relative value of individual, behavioural approaches in comparison with broader, population-shifting actions – a philosophical as well as evidential distinction that makes it an entirely appropriate question for local democracy. Should public health spending prioritise a park or an obesity service? Should alcohol policy be focused upon brief interventions for problem drinkers or regulation of licensing and cost? While not mutually exclusive, the relative emphasis placed upon these alternatives is critical to the future of health improvement. And while the evidence-based consensus stresses the greater potency of the latter, government policy strongly favours the former.

Public Health England

Curiously, while the reforms were intended to deliver public health responsibilities to the front line, national attention has been disproportionately focused upon the establishment and function of Public Health England (PHE). As an executive agency of the Department of Health, governed by the Civil Service Code, PHE has been criticised for being insufficiently independent of government. Its priorities are thought by many to fall squarely into an individualist, behaviour-oriented and medicalised model of health risk. This is, of course, in keeping with government philosophy and policy, and perhaps over-stresses the health improvement element of PHE's function as against its much larger health protection, healthcare and intelligence components.

In practice, PHE has to date had little impact upon health improvement or upon the function of public health at a local level, and is compromised by its lack of independence from government. It is said to be an evidence-based organisation, but that is a field already occupied by the National Institute for Clinical Excellence and a variety of academic interests, and PHE does not have the resources for development of new evidence or substantial evidence reviews. It promotes or is obliged to implement interventions whose evidence base is seriously challenged (health checks, ebola screening) but cannot champion effective legislative change (minimum alcohol pricing, sugar restriction).

Prospects

Can prevention realistically reduce either need or demand or both? The answer to this question depends, at least partly, on the level at which it is aimed.

Improved health for individuals, on an age-specific basis, unquestionably reduces the need and demand for healthcare on an age-specific basis. That is, a 50-year-old in 2015 has, on average, much lower healthcare needs than would have been the case for a 50-year-old in 1915 or 1965. But it is much less clear that the lifetime need for individuals alive in 2015

would be lower than it was in 1915. Indeed, the capacity of medicine and care to alleviate illness and suffering for individuals would suggest that it is likely to be much greater – potentially simply delaying need to a later age beset by multiple morbidities.

On the other hand, if prevention avoids a condition entirely – if an individual never develops diabetes and its complications, or never experiences dementia or arthritis – the lifetime needs of individuals may be markedly diminished, despite a period of late-life dependency. This is in keeping with the observation that healthier groups in society have *healthy life* expectancies that are disproportionately greater than their enhanced overall life expectancies.

The prospect for reducing need and demand through prevention, therefore, are likely to rest much more upon the avoidance and amelioration of chronic disease than upon integration and alternative provision of care. This is, presumably, why the *Five Year Forward View* focuses upon obesity and diabetes in its discussion of preventive activity, since effective action in this field holds the prospect of genuinely diminished need and demand.

The key problem will remain that prevention of this kind has a timescale of payback that is measured in decades – even lifetimes – rather than years. The cost-effectiveness of preventive interventions such as reduction and avoidance of smoking is unquestionable, but they remain poor relations in healthcare spending for this reason. In 2012 smoking accounted for 16 percent of deaths in England, but the entirety of spend on smoking cessation and tobacco control was a mere 0.16 percent of the NHS budget.

Realistic programmes of intervention will need to blend short-, medium- and long-term approaches pragmatically if they are to avoid discrimination or neglect of need, maximise any potential short-term savings, and still deliver genuine health improvement across the life course.

Some conclusions

To a large extent the latest restructuring of the NHS, in keeping with past experience, has been an expensive distraction rather than either the main cause of, or a solution to, its current problems. The penalties have been in exacerbating underfunding through their direct cost, and the loss of any effective infrastructure for NHS structural planning.

The latter is a gap that needs to be filled. Absence of accountable, governance structures other than for local public health, and lack of effective central/regional planning, continue to be serious problems in achieving optimal configuration from both clinical and cost perspectives. Without them, provider institutions are over-powerful and motivated by

perverse incentives – the interests of a trust are not necessarily the same as the best interests of the local population in terms of health and well-being.

In addition, aspirations for local clinical engagement and leadership feel remote, while heavy-handedness by the Care Quality Commission and Monitor reinforce blame culture, militating against the high morale and sense of ownership needed for a dynamic and innovative workforce.

More broadly, the future viability of the NHS – or for that matter, the cost-containment of any healthcare system – will depend upon maximising the proportion of an individual's life spent in good health, and minimising the costs of support for that part of life spent in frailty and need. To achieve this will require a balance of short-, medium- and long-term prevention.

How do we find our way out of this fix?

1. The NHS needs more funding – it is not the answer, but at the moment it is a world-class service provided remarkably cost-effectively and at constant risk of crisis.
2. Integration makes sense because it is better for patients and families, not because it is likely to save money.
3. If we want a viable system for the next generation, we need to invest *separately* and at realistic levels in prevention – not at the expense of current provision.
4. Public health in local authorities will be most potent by shifting broader population behaviours, not by being forced to act as a branch of NHS individual preventive care.
5. By focusing as great an effort as possible on secondary prevention – that is, on minimising and ameliorating chronic disease in those already afflicted – we can reduce or postpone needs and costs.
6. Local systems need to be capable of making decisions on infrastructure and distribution of NHS services, with the political nerve to weather local protests on closure and re-provision. The market will only do this if institutions are allowed to fail – far better that we plan and prepare than restructure through crisis.

