

DUE

NORTH

**Report of the Inquiry on
Health Equity for the North**

Due North: The report of the Inquiry on Health Equity for the North

Inquiry Chair: Margaret Whitehead

Report prepared by the Inquiry Panel on Health Equity for the North of England

First published in Great Britain in September 2014
by University of Liverpool and Centre for Local
Economic Strategies

Copyright ©University of Liverpool and Centre for
Local Economic Strategies, 2014

ISBN: 1 870053 76 1

Aknowledgements

We thank the many people who contributed to the Inquiry's work. This Inquiry was carried out by a panel chaired by Margaret Whitehead and supported by a secretariat from the Centre for Local Economic Strategies (CLES). The review was informed by 18 policy makers and practitioners, with expertise in the relevant policy fields (see appendix 1) and four discussion papers prepared by Ben Barr, David Taylor-Robinson, James Higgerson, Elspeth Anwar, Ivan Gee (University of Liverpool), Clare Bamba and Kayleigh Garthwaite (Durham University) and Adrian Nolan and Neil McInroy (CLES). This report was prepared by the Inquiry Panel supported by CLES (Neil McInroy, Adrian Nolan and Laura Symonds) and the WHO Collaborating Centre for Policy Research on Social Determinants of Health (Ben Barr). Public Health England provided financial support for the conduct of the Inquiry and the gathering of evidence but played no part in the decisions or conclusions of the Inquiry Panel.

CONTENTS PAGE

Preface	4
Foreword	5
Executive Summary	6
1 Principals and processes of the inquiry	18
1.1 Introduction: the aims fo the inquiry	18
1.2 The Inquiry Panel	19
1.3 The process	19
1.4 Principles of the inquiry	20
1.5 The role of evidence in developing the recommendations	21
2 Current policy context	22
2.1 The opportunities offered by public health in local government	22
2.2 Action on health inequalities in an age of austerity	23
2.3 Devolution: having the power to make a difference	25
3 Evidence	27
3.1 Health inequalities and the North of England	27
3.2 Economic development and living conditions	31
3.3 Devlopment in early childhood	49
3.4 Devolution and democratic renewal	55
3.5 The role of the health sector	64
4 Recommendations	72
4.1 Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England	73
4.2 Recommendation 2: Promote healthy development in early childhood	78
4.3 Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health	81
4.4 Recommendation 4: Strengthen the role of the health sector in promoting health equity	85
5 References	88
Appendix 1: Witnesses to the Inquiry	99

PREFACE

Life is not grim up North, but, on average, people here get less time to enjoy it. Because of poorer health, many people in the North have shorter lifetimes and longer periods of ill-health than in other parts of the country. That health inequalities exist and persist across the north of England is not news, but that does not mean that they are inevitable.

While the focus of the Inquiry is on the North, it will be of interest to every area and the country as a whole.

This has been an independent inquiry commissioned by Public Health England. We particularly wanted and welcome fresh insights into policy and actions to tackle health inequalities within the North of England and with the rest of the country, in the context of the new public health responsibilities locally and nationally, and the increasingly live debate about greater economic balance.

I would like to thank Professor Whitehead, her panel, witnesses to the Inquiry and the Centre for Local Economic Strategies for the time, energy and commitment that has resulted in this report

PHE's own interim response to the issues and recommendations from this inquiry is published alongside this report and we will produce a fuller response at a later date, when we have had time to explore and consider the issues in greater depth. We look forward to contributing to stimulating discussion and debate with partners over the coming months.

*Paul Johnstone
Public Health England
August 2014*

FOREWORD

We have lived with a North-South health divide in England for a long time, illustrated by the shocking statistic that a baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in Richmond. This gap is not static but has continued to widen over recent decades. This regional health divide masks inequalities in health between different socio-economic groups within every region in England which are just as marked: health declines with increasing disadvantage of socio-economic groups wherever they live in the country.

By and large, the causes of these health inequalities are the same across the country – and are to do with differences between socioeconomic groups in poverty, power and resources needed for health; exposure to health damaging environments; and differences in opportunities to enjoy positive health factors and protective conditions, for example, to give children the best start in life. It is, however, the severity of these causes that is greater in the North, contributing to the observed regional pattern in health. It also marks out the North as a good place to start when inquiring into what can be done about social inequalities in health in this country. There may be lessons to be learnt for the whole country.

There are more pressing reasons, however, for setting up this Inquiry on Health Equity for the North at this point in time. The austerity measures introduced as a response to the 2008 recession have fallen more heavily on the North and on disadvantaged areas more than affluent areas, making the situation even worse. Reforms to the welfare system are potentially increasing inequalities and demand for services. At the same time, there are increasing calls for greater devolution to city and county regions

within England. There is a growing sense that now is the time to influence how the process of devolution happens, so that budgets and powers are decentralised and used in ways that reduce economic and health inequalities.

It is against this background that the Inquiry Panel developed its' recommendations – recommendations that are based on an analysis of the root causes of the observed health inequalities. A guiding principle has been to build on the assets and agency of the North. There are plenty of ideas, therefore, about what agencies in the North could and should do, made stronger by working together, to tackle the causes of health inequalities. These are centred around the twin aims of the prevention of poverty in the long term and the promotion of prosperity, by boosting the prospects of people and places. They are also about how Northern agencies could make best use of devolved powers to do things more effectively and equitably.

The Panel is keen to stress, however, that there are some actions that only central government can take. Government policy is both the cause and the solution to some of the problems analysed by the Inquiry. The report therefore sets out what central government needs to do, both to support action at the regional level and to re-orientate national policies to reduce economic and health inequalities. There is an important role too for national health agencies, including the NHS and Public Health England. The aim of this report is to bring a Northern perspective to the debate on what should be done about a nationwide problem. We are optimistic that something can be done to make a difference and that this is the right time to try.

*Margaret Whitehead
Chair, Inquiry on Health Equity for the North
August 2014*

EXECUTIVE SUMMARY

Why have an inquiry into health inequalities and the North?

The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments. Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country. The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health than a boy born in Richmond in London. Similarly, a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and prosperous socio-economic groups in the North than in the rest of the country. It is against this background that this Inquiry was set up.

Aims of the inquiry

In February 2014, Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Review Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North' - a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This programme was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry is to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place-based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bambra, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period February to July 2014. The policy sessions involved the submission of written discussion papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants). During the three further deliberative sessions held by the Inquiry the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

This report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

The burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South;

Policy drivers of inequalities and solutions

1. Economic development and living conditions

The difference in health between the North and the rest of England is largely explained by socioeconomic differences, including the uneven economic development and poverty. One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher unsecured debts in the North, all of which have an adverse impact on health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health. Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England. The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community. Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course.

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent

people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental and physical health problems. Poor psychosocial conditions at work increase risk of health problems, in particular cardiovascular conditions and mental health problems. More precarious forms of employment, including temporary contracts, are also increasing and these have been associated with increased health risks.

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.

This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties. In terms of physical health, debt has been linked to a poorer self-rated physical health, long term illness or disability, chronic fatigue, back pain, higher levels of obesity and worse health and health related quality of life.

What could be done differently?

The evidence reviewed by the panel has outlined a number of actions that have the potential to address the economic and employment causes of health inequalities. This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future, not least by investing in people (improving skills and health and hence employment prospects), as well as investing in places. This strategy links public service reform to economic development in the North, to refocus services on preventing poverty and promoting prosperity.

2. Early childhood as a critical period

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe. Within England, the health of children is generally worse in the North, reflecting the higher levels of child poverty.

There is a large body of evidence demonstrating that early disadvantage tracks forward, to influence health and development trajectories in later life,

and that children who start behind tend to stay behind.

For example, children living in poverty and experiencing disadvantage in the UK are

more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have repeatedly shown that providing better support early in children's lives is the most effective approach to significantly reduce inequalities in life chances. In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities. In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty. To address these targets, a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this period. Unfortunately, we are now seeing signs that these achievements are being undone. For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has

estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the health and well-being of children has the potential to engender a new commitment to investment in the early years.

The evidence indicates that two strands of action are required to significantly reduce child health inequalities at a population level. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises. Those countries in Europe that do have more adequate social protection experience better child health outcomes. The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Secondly, a system of high quality universal early years child care and education support is also necessary. In Nordic countries, a child's life chances are not so dependent on how privileged their

parents were than they are in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across society would effectively reduce inequalities. Providing any education is not enough, though, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects. This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities. The evidence base for these early interventions is strong.

3. Devolution: having the power to make a difference at the right spatial scale

The evidence suggests that there are three ways through which levels of community control and democratic engagement have an impact on health. Firstly, those who have less influence are less able to affect the use of public resources to improve their health and well-being. The Northern regions, for example, have had limited

Northern regions have had limited collective influence over how resources and assets are used and this has hindered action on health inequalities.

collective influence over how resources and assets are used in the North of England and this has hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social

capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.

There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health. A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities. Countries with long-term social-democratic governments tend to have more developed preventive health services. US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability. There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social isolation and nurture a sense of community, trust and community competence. Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem,

social networks, community cohesion and improved access to education leading to increased skills and paid employment. Evidence from the 65 most deprived local

authorities in England shows that, as the proportion of the population reporting that they can influence decisions in their local area increases, the average level of premature mortality and prevalence of mental illness in the area declines.

A constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe, both political and economic power are concentrated in London and the surrounding area and this has contributed to the large inequalities between regions.

The disproportionate cuts to local government budgets currently being implemented are exacerbating the problem. Successful regions will have control over the prerequisites of growth, such as skills, transport and planning.

What could be done differently?

Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England. Simply devolving power to city regions and combined authorities, however, will not, on its own, address inequalities. Giving local areas greater control over investment for economic development will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. Devolution of power and resources to local administrations needs to be accompanied by greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable

to people living in the North, but decisions made by combined authorities or local economic partnerships will seem no more democratic unless there is greater transparency and participation.

There is the potential for devolution within England to herald a new approach to health inequalities

There is the potential for devolution within England to herald a new approach to health inequalities that is based on fundamentally shifting power from central government to regions, local authorities and communities. But only if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities – allowing them to do the right things at the right spatial scale.

None of this, however, should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

4. The vital role of the health sector

We did not consider that the observed health inequalities between the North and the rest of England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, these could not account for the size

and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this, NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need must be maintained.

The NHS can influence health inequalities through 3 main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care,

free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase

health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces health inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England. There is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes. This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it should not be at the expense of investment earlier in the life course, which is a vital component of all health inequalities strategies.

Access to NHS care when ill has helped to reduce health inequalities, ameliorating the health damage caused by wider determinants outside the health sector.

Thirdly a more community-orientated model of primary care needs to be encouraged that fully integrates support across the determinants of health. This includes enabling people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.

Fourthly a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.

Finally the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Recommendations

Tackling these root causes leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations are explained in detail in Section 4. These recommendations are formulated from a Northern perspective and address the core question: what can the North do to tackle the health equity issues revealed in this report? This perspective does not mean that we discount national actions – far from it – we give two types of recommendations for each high-level recommendation:

- 1) What can agencies in the North, do to help reduce the health inequalities within the North and between the North and the rest of England?
- 2) What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

We believe that the recommended actions would benefit the whole country, not just the North.

Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England.

Agencies in the North should work together to:

- Draw up health equity strategies that include measures to ameliorate and prevent poverty among the residents in each agency's patch;
- Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by re-orientating services to boost the prospects of people and place. This includes establishing integrated support across

the public sector to improve the employment prospects of those out of work or entering the labour market.

- Adopt a common progressive procurement approach to promote health and to support people back into work;
- Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery;
- Implement and regulate the Living Wage at the local authority level;
- Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.
- Assess the impact in the North of changes in national economic and welfare policies;

Central government needs to:

- Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people into work;
- Extend the national measurement of the well-being programme to better monitor progress and influence policy on inequalities;
- Develop a national industrial strategy that reduces inequalities between the regions;
- Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular;
- Expand the role of Credit Unions and take measures to end the poverty premium;
- Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market;

- End in-work poverty by implementing and regulating a Living Wage;
- Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL);
- Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets;
- Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.

Recommendation 2: Promote healthy development in early childhood.

Agencies in the North should work together to:

- Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need;
- Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs, so that all children achieve an acceptable level of school readiness;
- Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach;
- Collect better data on children in the early years across organisations so that we can track changes over time;
- Develop and sign up to a charter to protect the rights of children to the best possible health.

Central government needs to:

- Embed a rights based approach to children's health across government;
- Reduce child poverty through the measures advocated by the Child Poverty Commission which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;
- Reverse recent falls in the living standards of less advantaged families;
- Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated;
- Invest in raising the qualifications of staff working in early years childcare and education;
- Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused according to need;
- Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.
- Make provision for universal, good quality early years education and childcare proportionately according to need across the country.

Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.

Agencies in the North should work together to:

- Establish deep collaboration between combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities;
- Take the opportunity offered by greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people into employment;
- Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.
- Develop community led systems for health equity monitoring and accountability;
- Expand the involvement of citizens in shaping how local budgets are used;
- Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development;
- Help develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at local and national levels;

Central government needs to:

- Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve;

- Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities;
- Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities;
- Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.

Recommendation 4: Strengthen the role of the health sector in promoting health equity.

Public Health England should:

- Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services;
- Support local authorities to produce a Health Inequalities Risk Mitigation Strategy;
- Help to establish a cross-departmental system of health impact assessment;
- Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise Partnerships and combined authorities;
- Contribute to a review of current systems for the central allocation of public resources to local areas;
- Support the development a network of Health and Well-being Boards across the North of England with a special focus on health equity;
- Collaborate on the development of a charter to protect the rights of children;
- Work with Healthwatch and Health and Well-being Boards across the North of England to develop community-led systems for health equity monitoring and accountability.

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

- Lead the way in using the Social Value Act to ensure that procurement and commissioning maximises opportunities for high quality local employment, high quality care, and reductions in economic and health inequalities;
- Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained;
- Work with local authorities, the Department for Work and Pensions (DWP) and other agencies to develop 'Health First' type employment support programmes for people with chronic health conditions;
- Work more effectively with local authority Directors of Public Health and PHE to address the risk conditions (social and economic determinants of health) that drive health and social care system demand;
- Support Health and Well-being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities;
- Provide leadership to support health services and clinical teams to reduce children's exposure to poverty and its consequences;
- Encourage the provision of services in primary care to reduce poverty among people with chronic illness, including, for example, debt and housing advice and support to access to disability-related benefits.

1 PRINCIPLES AND PROCESSES OF THE INQUIRY

The aim of this inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

1.1 Introduction: the aims of the inquiry

In February 2014 Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Inquiry Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North', a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This public health call for action was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

In particular the panel has sought to develop recommendations that:

- Build on the assets and resilience of the North, rather than presenting the North as a victim. This includes identifying policy that enhances the capacity of communities, organisations and enterprises in the North to build on their assets

and develop their collective capacity to influence inequalities in health.

- Enable a platform for local authorities, city and county regions, Health and Well-being Boards and the other collaboratives across the North to act on the national stage in lobbying for policies that reduce inequalities and the health divide between the North and the rest of England.
- Make the most of the new public health responsibilities of local government for the health and well-being of their local populations and the reduction of health inequalities.
- Address the root causes of health inequalities - the conditions in which people grow, live, work and age - within the North as well as between the North and the rest of England.
- Are supported by what is known about the mechanisms that generate health inequalities and effective policy approaches, building on previous reviews of health inequalities.

Although commissioned by PHE, the evidence presented in this report and its recommendations have been independently developed by the Inquiry Panel.

1.2 The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. It was chaired by Professor Margaret Whitehead, W H Duncan Chair of Public Health at the University of Liverpool and Head of the World Health Organisation (WHO) Collaborating Centre for Policy Research on the Social Determinants of Health. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bamba, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

1.3 The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period January to July 2014. The policy sessions involved the submission of written evidence papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants and the accompanying Appendices document for the submitted evidence papers). The Inquiry Panel discussed the evidence and policy implications with this wider group of experts and practitioners, at each of these policy sessions. The policy sessions focused on 3 priority areas that had been identified as having particular relevance for addressing health inequalities affecting the North of England.

- Healthy economic development and ensuring an adequate standard of living;
- Promoting healthy development in early childhood; and
- Devolution and democratic renewal.

During the three further deliberative sessions held by the Inquiry, the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

The report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations, acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

1.4 Principles of the inquiry

The inquiry uses the term health inequalities to describe the systematic differences in health between social groups that are avoidable by organised action and are considered unfair and unjust.¹ Three general principles run through the review and inform its analysis and recommendations.

- Firstly that reducing health inequalities is a matter of **social justice**, as the WHO Commission on Social Determinants of Health concluded, it is a 'social injustice that is killing on a grand scale.'²
- Secondly that inequality in health arises because of inequalities in **power** and influence. Reducing health inequalities 'can be thought of as increasing the freedom and power among people with the most limited possibilities of controlling and influencing their own life and society.'³
- Thirdly that these inequalities in power result in inequalities in the **resources** needed for health including material and psychosocial working and living conditions, education opportunities, built environments and opportunities for social participation.

These inequalities in power and resources produce a **social gradient** in health: people and communities have progressively better health the better their socioeconomic conditions. Therefore effective approaches to decrease health

inequalities need to reduce inequalities in resources across the whole gradient and not just amongst the people at the bottom. However a shift in the resources for health across the social gradient will only be sustained if it is accompanied by an increase in the power and influence people have over those resources.

There have been a series of reviews of health inequalities in the UK, Europe and globally, and the purpose of this inquiry is not to repeat the work of these reviews, but to learn from and move beyond them in developing action on health inequalities for a specific region – the North of England (the NHS areas of Yorkshire and the Humber, North West and North East). The evidence from previous reviews is clear. The highest priority for action should be to ensure a good start to life for every child and to maintain an adequate standard of living across the life course that enables everyone to participate in society and maintain good health. However health inequalities have proved themselves to be highly persistent. Economic and social inequalities are perpetuated within places and over generations. The 2013 WHO Europe review of Determinants and the Health Divide recognized that reducing health inequalities involves the 'whole-of-government' and 'whole-of-society'.⁴ The challenge is how to bring about this change. Achieving and sustaining action will involve a step change in how the public, particularly the most disadvantaged groups, are engaged in and influence policy, a shift in the model of economic development and a strategy that prevents the perpetuation of health risks from one generation to the next. This led the Inquiry to focus on the 3 priority areas outlined in 1.3, in developing its recommendations:

The Inquiry has sought to bring a fresh perspective to the issue of health inequalities that focuses on preventing inequalities occurring in the future as well as ameliorating the impact of current inequalities.

The concepts of 'place', 'governance' and 'assets', have been important to the Inquiry's approach. Firstly, by emphasizing the geographical distribution of health inequalities in England as well as differences between socioeconomic groups within the North, this inquiry highlights the importance of 'place' in both the generation of health inequalities and the policies that address them. The social, economic and political processes that influence health inequalities intersect in the places where people live and work. It is here that we need to start in order to bring about this change in the 'whole-of-government' and 'whole-of-society'. Secondly, it is important to recognise that previous approaches to tackle health inequalities in England and beyond have, in the main, fallen short of their objectives. The WHO European review of the health divide has analysed the reasons for this lack of progress.⁴ It concludes that they result from a failure in governance and accountability, which has meant that policies have not sufficiently addressed the root causes of health inequalities, in particular the inequalities in power and resources needed for health. Reducing inequalities in health requires coherence of action across a range of stakeholders working in the interests of the public. The Inquiry has therefore sought to develop approaches that enable new systems of governance and accountability for health equity, in particular accountability to the public, which support coordinated action that influences the places in which people live, work and flourish. Thirdly, the inquiry has sought to develop policy options that build on the assets of the North, enabling everyone - from communities to organisations and enterprises - to develop their collective capacity to influence inequalities in health.

1.5 The role of evidence in developing the recommendations

The Inquiry has sought to develop recommendations that are supported by a robust analysis of the causes of health inequalities within the North of England and between the North and the rest of England. It is widely agreed that social policies working at the population, rather than individual, level have the greatest potential to reduce health inequalities by addressing the social conditions and economic and political systems that contribute to and sustain them. However these types of 'upstream' policies present the greatest challenges for researchers trying to evaluate health and other impacts. This results in the 'inverse evidence law' whereby the availability of evidence tends to vary inversely with the potential impact of the intervention.⁵ The recommendations have therefore been informed by a broad range of evidence including the experience of the panel members of what is feasible and what is likely to have the greatest impact.

2 CURRENT POLICY CONTEXT

The inquiry comes at a time when there are some specific threats and opportunities for action on health inequalities in general and the North-South health divide in particular.

The inquiry comes at a time when there are some specific threats and opportunities for action on health inequalities in general and the North-South health divide in particular. In 2013 public health responsibilities that had been part of the NHS since 1974 were transferred back to local government. However this happened at a particularly challenging time for councils. The programme of austerity measures that continues to be pursued by the UK government is hitting local government particularly hard and reforms to welfare are potentially increasing inequalities and demand for services.⁶ Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England.^{7,8} The recommendations of the Inquiry need to be seen in the context of these developments in national policy as outlined in more detail below. The Inquiry Panel has sought to develop recommendations that make the most of these developments whilst minimising the risks for health inequalities.

2.1 The opportunities offered by public health in local government

The transfer of public health from the NHS to local government has been welcomed. It is local government services, such as housing, economic development, culture, leisure and environmental health, that have the most potential to improve public health outcomes. Situating public health departments within local authorities clearly enhances the opportunities for them to influence these determinants of health.

An important function of local government is also to 'shape places' by representing, engaging and leading the citizens and communities in a place to collectively develop local identity and promote well-being.⁹ The implications of this role for improving the health of the people living in a place, even in the face of adverse national and global trends, has not yet been fully recognized or fully realised. The new public health role for local government provides an opportunity to develop this further. The transition of Directors of Public Health and their teams from PCTs to local authorities was not just a transition between organisations, it was a transition from an organisation whose primary responsibility was the commissioning of services to another organisation whose primary responsibility is democratic governance. This is an opportunity to fully integrate health goals into all sectors by incorporating health and equity considerations as a standard part of decision-making across sectors and policy areas.

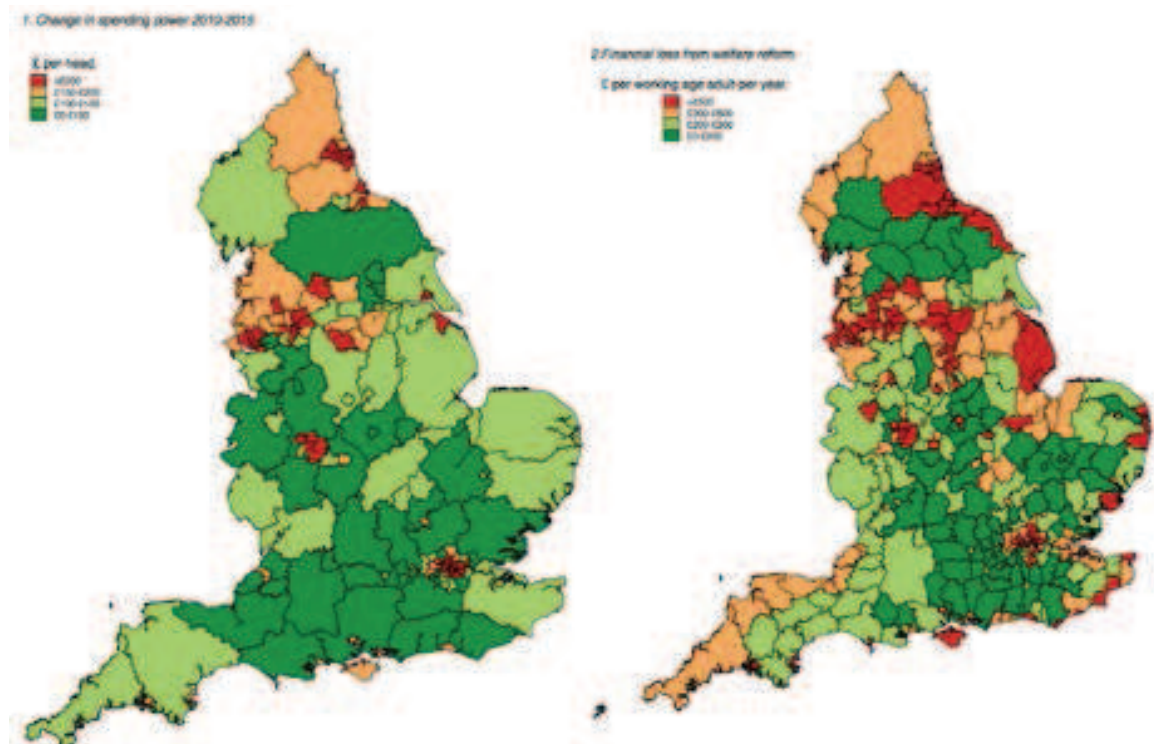
2.2 Action on health inequalities in an age of austerity

The capacity for local government to influence the health and well-being of the places they represent is limited by a programme of austerity that is hitting councils hardest in some of the poorest parts of the North. In 2013 the Government allocated a ring-fenced public health budget to local authorities. The Secretary of State for Health at the time said this should be used to tackle 'poverty-related health need'.¹⁰ This 'public health grant' represents approximately 3% of local government expenditure and only 1% of the combined local expenditure of the NHS and local government in an area.^{11,12} This in itself would be

inadequate to address the health effects of poverty, but given that this grant was transferred to councils at a time when their core budgets are being cut by nearly 30%, it is difficult to see how, in these circumstances, local government can have an impact on health inequalities. In fact these cuts are likely to make health inequalities worse because they are disproportionately hitting the poorest areas with the worst health outcomes hardest (see Figures 1 and 2). On top of these cuts to local authority budgets, more deprived areas are experiencing large financial losses due to welfare reform with the three regions of northern England losing an estimated £5.2bn a year.¹³ This has an impact not just on the individuals and families facing reduced incomes from welfare benefits, but also represents a large loss to the local economy (see Figure 1).

Figure 1: Map of change in local authority spending power and financial losses from welfare reform for each council in England.

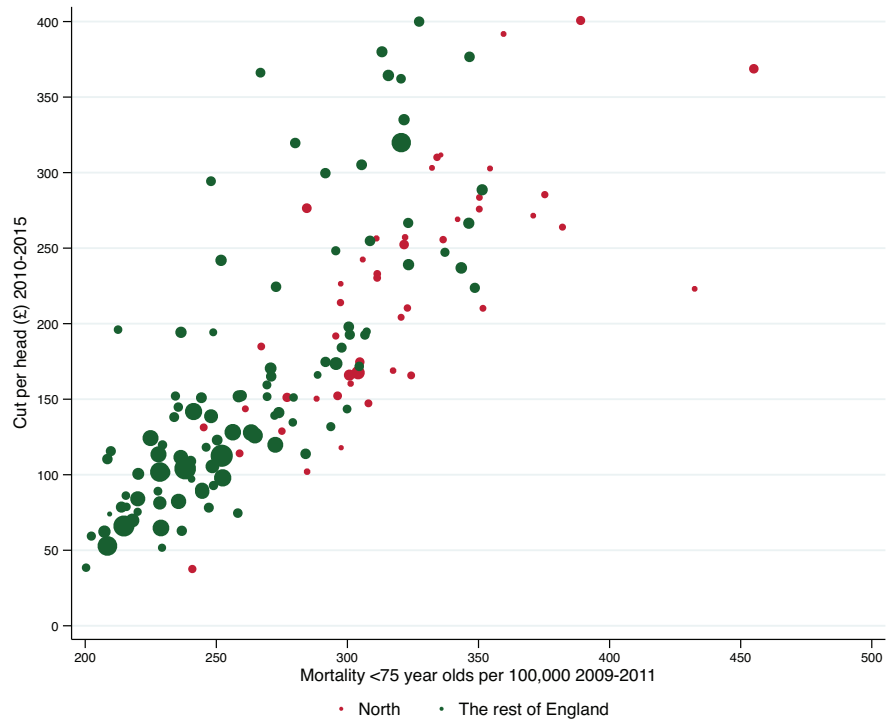
Map shows that cuts in council funding and financial losses from welfare reform are greatest in the North



Sources: 1. DCLG - Local government financial settlement; 2. Beatty and Fothergill 2014

Figure 2: Council cuts per head correlated against premature mortality rates

Cuts in council budgets are greatest in areas in the North of England, with the worst health



Sources: 1. DCLG - Local government financial settlement, 2. Public Health England - Longer Lives

Whilst the health effects of these policies may not be felt immediately the international evidence from previous periods of welfare expansion and contraction indicate that inequalities in both mortality and morbidity increase when welfare services are cut.¹⁴⁻¹⁷ There is a pressing need to ensure that sufficient resources are available to address inequalities and where a reduction in government spending is unavoidable it needs to be carried out in a way that does not exacerbate existing inequalities.

2.3 Devolution: having the power to make a difference

A further constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe with central government controlling a higher proportion of public spending than any other OECD country in Europe (see section 3.5). The concentration of political and economic power in London and the surrounding area has contributed to the large inequalities between regions.¹⁸ The present Coalition Government has committed to greater decentralisation, as did the previous government. However the UK continues to become more centralised with local government controlling a declining proportion of public expenditure (see section 3.5). The disproportionate cuts to local government budgets currently being implemented are exacerbating this.

Increasingly the new combined authorities and core cities in England are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties this is needed to drive economic growth and reduce regional inequalities in England.^{7,8} The focus has so far been on enabling greater local control over investment in infrastructure and skills. The review of economic growth commissioned from Lord Heseltine by the Prime Minister recommended devolving £49bn of central government funding to Local Economic Partnerships. The Coalition Government have begun a process of devolving

limited responsibilities and funding to cities and their surrounding areas through a programme of 'City Deals' and 'Growth Deals'. The growth review by Lord Adonis for the Labour party proposes making combined authorities (for both Cities and County Regions) the foundation for future devolution with £30bn being transferred from central to local government for skills, infrastructure and economic development. However it remains to be seen whether proposals from the current government or the opposition translate into a real commitment to the devolution of powers. In England the 'history of the last 30 years is marked by a series of well-intentioned devolution initiatives, which have often evolved into subtle instruments of control.'⁹

The concentration of political and economic power in London and the surrounding area has contributed to the large inequalities between regions

Devolution could support effective action on health inequalities, but only if three conditions are met. Firstly, local economic growth needs to promote health and reduce inequalities. Giving local areas greater control over investment for economic development, will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities. Devolution must be about securing a fairer share of the proceeds of growth. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. How the devolved resources for skills, infrastructure, employment and business are used will have major implications for health inequalities.

Secondly, devolution needs to address the inequalities in power that underlie inequalities in health. It needs to increase the power and influence that local communities have over public policy and the use of public resources. This means greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable to people living in the North, but decisions made by combined authorities or Local Economic Partnerships will seem no more democratic unless there is greater transparency and participation. Key decisions are better made if they can be influenced, or even made, by those most affected, and local decision-making and control can enable solutions to be developed that build on the assets of citizens rather than being imposed on them.

Thirdly, devolution needs to enable public services to be developed and improved so that they prevent future poverty and inequalities as well as ameliorating the effect of current inequalities. This means integrating, coordinating and sequencing all public services so that they reflect how people live their lives, rather than reflecting the organisational boundaries of public services. Importantly, with greater local control and flexibility about how resources are used, integrated public services can be developed to enable all young children to get the best start in life, to be ready for and successful at school, support transitions from school into training and employment, prevent illness and the consequences of illness throughout life and help people who are out of work to get back into employment.

There is the potential for devolution within England to herald a new approach to the challenges faced by the regions, based on fundamentally shifting power from central

government to regions, local authorities and communities. This will only happen if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities.

None of this however should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

The role of national government in addressing health inequalities remains of the utmost importance.

3 EVIDENCE

This section outlines the evidence and analysis underlying the recommendations made by the panel.

This section outlines the evidence and analysis underlying the recommendations made by the panel. Firstly we outline the current situation of health inequalities affecting the North of England and trends in those inequalities over the past decade. Next we outline the evidence for action across the three priority areas identified in the introduction:

- Economic development and the standard of living;
- Early childhood;
- Devolution and democratic renewal;

Finally we outline the role of the health sector in reducing health inequalities.

3.1 Health inequalities and the North of England

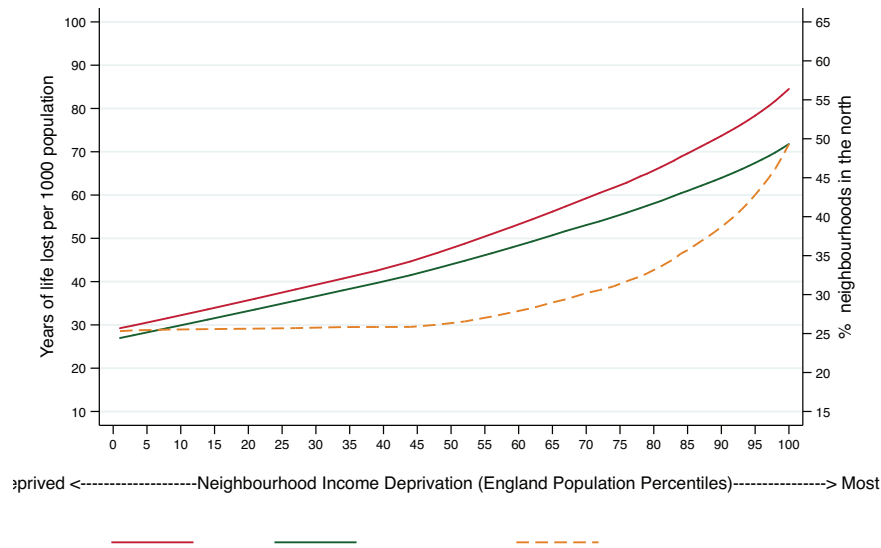
The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments.¹⁹ Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country.²⁰ The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health, than a boy born in Richmond in London. Similarly a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of

England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and privileged socio-economic groups in the North than in the rest of the country (see Figure 3). The historical growth and decline of industry in the North has resulted in concentrations of poverty that have persisted in areas for generations. This exacerbates health inequalities and has left a legacy of high levels of chronic disease and disability. It is the combination of these factors: adverse socioeconomic conditions that disproportionately affect the North and a steeper social gradient in health that results in the North-South health divide shown in Figure 4.

Figure 3: Years of Life Lost by neighbourhood income level, the North and the rest of England, and the % of neighbourhoods at each income level that are in the North

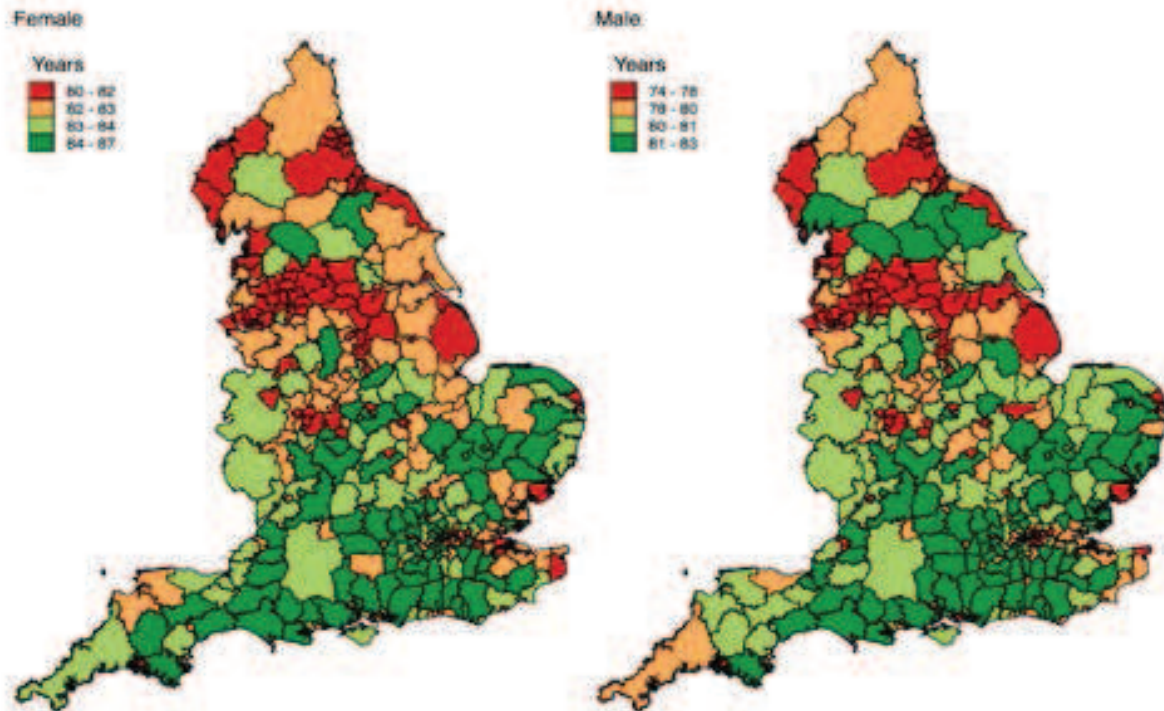
Graph shows poorer health across all neighbourhood income levels in the North, a steeper 'social gradient' in health in the North, and a higher concentration of poor neighbourhoods



Years of Life lost (YLL), from deaths under the age of 75, 2008-2012, lowest smoothed lines. Source: PHE and DCLG.

Figure 4: Life Expectancy amongst males and females by LA, 2009-2012

Map shows lower life expectancy in the North



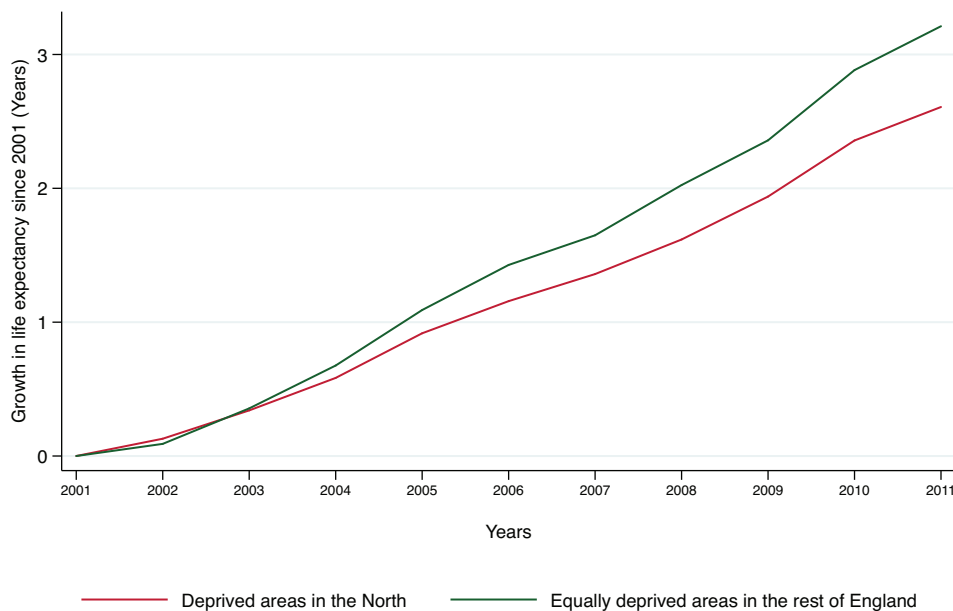
Source: HSCIC.

Between 1999 and 2010 the government pursued a systematic strategy to reduce inequalities in health in England. Although this strategy fell short of fully achieving its objectives, there are indications of some progress.²¹ The gap in mortality amenable to healthcare, infant mortality, and male life expectancy, between the most and least deprived areas all reduced during this time.^{22,23} Falls in inequalities in infant mortality occurred alongside large falls in child poverty (see section 3.4). A policy of allocating an increasing proportion of NHS resources to poor areas was associated with declining inequalities in mortality amenable to healthcare²³ (see section 3.6). Reductions in inequalities in male life expectancy between areas were in part explained by the large fall in unemployment in deprived areas

that occurred prior to the recent economic crisis.²⁴ However, on average, deprived areas in the North have experienced smaller increases in life expectancy than areas with similar levels of deprivation in the rest of England (see Figure 5). In particular deprived boroughs in London experienced large increases in life expectancy over the last decade. This suggests that for some reason it has been harder to gain the same level of health improvement in deprived areas in the North as compared to deprived areas in the South. This could reflect different levels of investment or that determinants of poor health in the North are more intractable and require different approaches.

Figure 5: Trend in life expectancy in deprived areas in the North and in the rest of England

Graph shows how life expectancy has increased less for people living in deprived areas in the North compared to people living in areas with a similar level of deprivation in the rest of England.



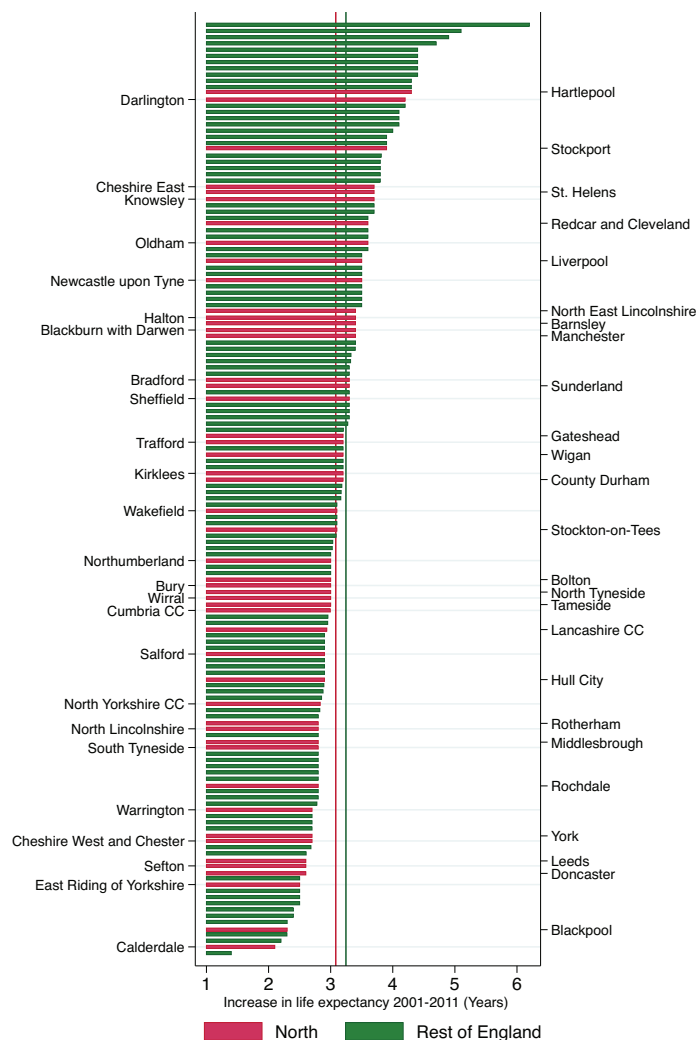
Deprived areas defined as being the 20% most deprived local authorities in England. Life expectancy calculated as weighted average for groups of local authorities. Source: HSCIC

Whilst local authorities in the North have on average experienced smaller improvements in health, these averages hide a number of exceptions to this pattern. Some of the most deprived local authorities in the North have bucked this trend (see Figure 6). Blackburn with Darwen, Halton, Hartlepool, Knowsley, Liverpool and Oldham all had some of the lowest levels of

life expectancy in 2001¹ and since then they have all experienced greater improvements in life expectancy than the national average. An important question, which remains largely unanswered, is – what has enabled some areas to improve health outcomes in the face of adverse circumstances, whilst other places have struggled?

Figure 6: Increase in life expectancy between 2001 and 2011, Local Authorities in England

Graph shows how much life expectancy increased over the past decade for people living in each local authority in England.



Life expectancy calculated as average of male and female life expectancy. Source: HSCIC.

3.2 Economic development and living conditions

Disturbing trends

The pattern of economic growth

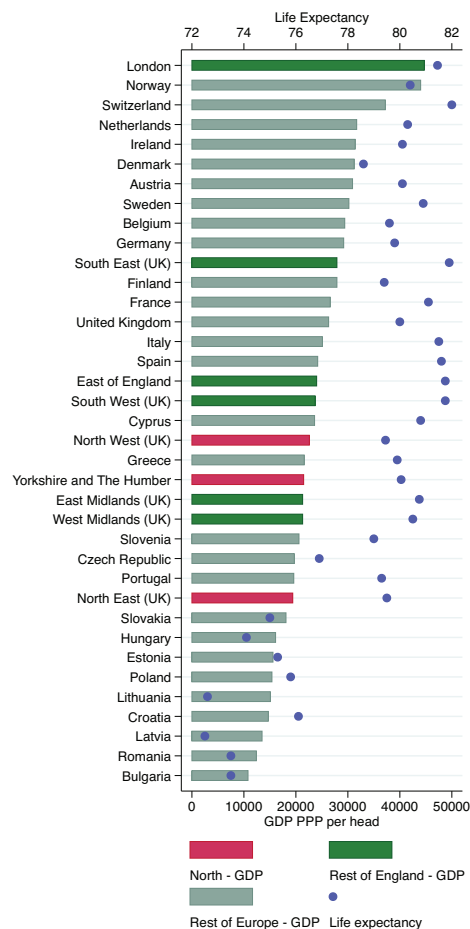
The difference in health between the North and the rest of England is largely explained by socio-economic differences.²⁰ Whilst the historical growth and subsequent decline of heavy industry in the North has had long-term adverse consequences for both the economy and for health, more recent economic policy has exacerbated this situation. Over the last decade the model of economic growth pursued in the UK has been predicated upon the accumulation of debt, low wages in many sectors, and a disproportionately large financial sector.²⁵ The North of England has found itself on the wrong side of policies that have privileged the accumulation of financial assets ahead of the creation of sustainable work. Economic growth in England has led to an increase in economic inequalities both between individuals and between regions, with the UK now having the largest difference in economic output between regions of any country in Europe.²⁵ In recent years many regional administrative structures have been dismantled, including Government Offices for the Regions, Regional Development Agencies, posts of 'Minister for the Regions' and Strategic Health Authorities. This has potentially limited the capacity of government to address English regional imbalances.²⁶ The economic gap between regions has widened to such an extent that they could be different countries, whilst the GDP of London is comparable to Norway, the GDP of the North East is similar to Portugal (see figure 7). Patterns of health largely mirror these economic differences. The

2008 recession, disproportionately hit areas of the North of England, particularly the North East, further widening inequalities,²⁷ and the economic recovery does not appear to be addressing these issues, with jobs growth concentrated in London and the South East.²⁸ Without a radical change in strategy the recovery is likely to repeat the mistakes of the past and further exacerbate the North-South Divide.

Without a radical change in strategy the recovery is likely to repeat the mistakes of the past and further exacerbate the North-South Divide.

Figure 7: GDP per head and life expectancy levels across the regions of England and European countries

Graph shows how GDP and life expectancy for each of the regions of England compares to countries in Europe.



Source: EUROSTAT 2010.

The unemployment gap between the North and the rest of England

The difference in economic growth between the North and the rest of England has had major implications for people's chances of employment. Over the past 20 years the North has consistently had lower employment rates than the South for both men and women²⁹ This is associated with the lasting effects of de-industrialisation.³⁰ In the latter part of the 20th century, there

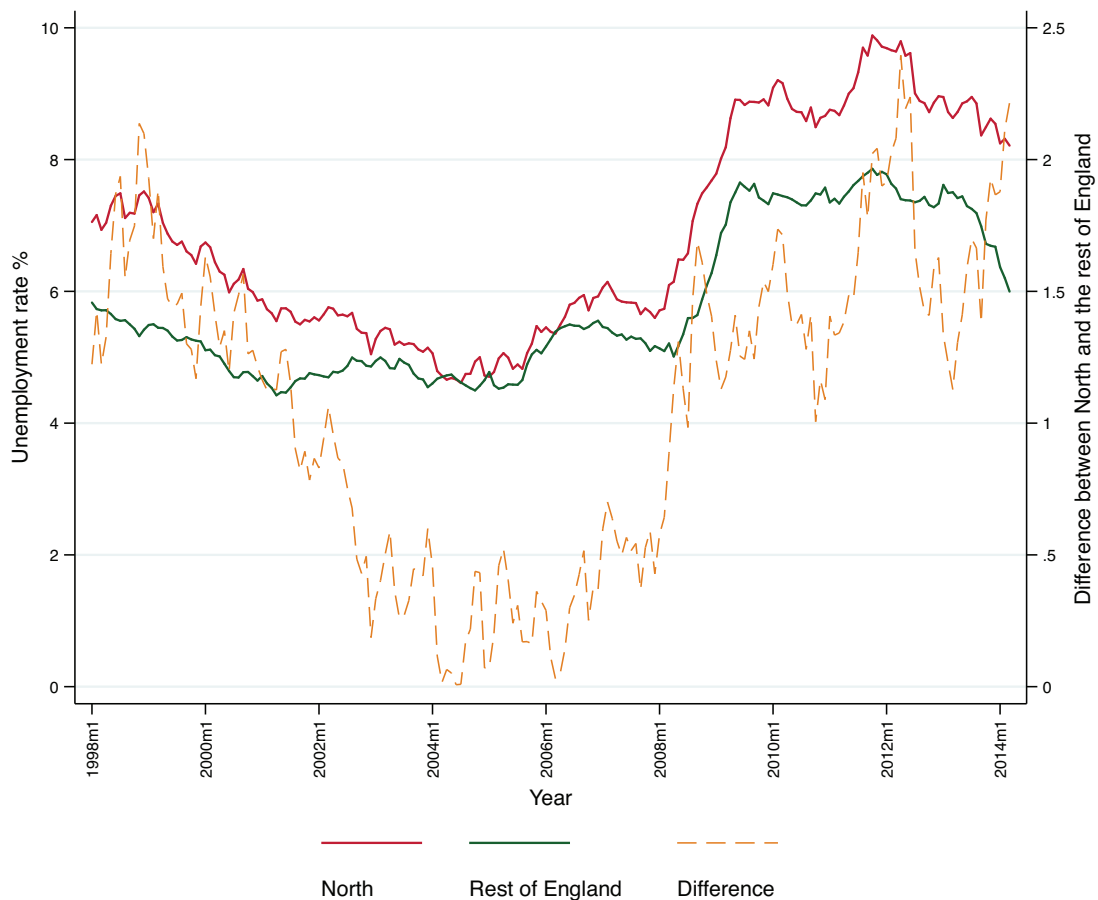
were regionally concentrated falls in the demand for labour (most notably in the North East and North West), particularly affecting those with less education³¹ The current unemployment rate is markedly higher in the North at 9% as compared to 7% in the rest of England and a higher proportion of the working age population are not in the labour market at all (24%). This 'economic inactivity' in the North is partly caused by high levels of disability with 9% of the working age population claiming disability benefits.³²

However some progress was made at narrowing this unemployment gap during the period of economic growth that followed the 1990's recession. The gap in the unemployment rate between the North and the rest of England was almost eliminated by 2006, with the North East experiencing the largest fall in unemployment of any region outside London. There is evidence that this helped narrow health inequalities in some

areas.²⁴ However the onset of the economic crisis in 2008 has reversed this situation and the gap in unemployment is once again as large as it was in the 1990's (see Figure 8). One of the limitations of economic growth that is based on unsecure forms of employment is that when the inevitable financial crisis arrives, these gains rapidly disappear.

Figure 8: Unemployment rate from 1998 to 2014 in the North and the rest of England

Graph shows how the gap in unemployment between the North and the rest of England had narrowed until the 2008 recession, when it widened again.



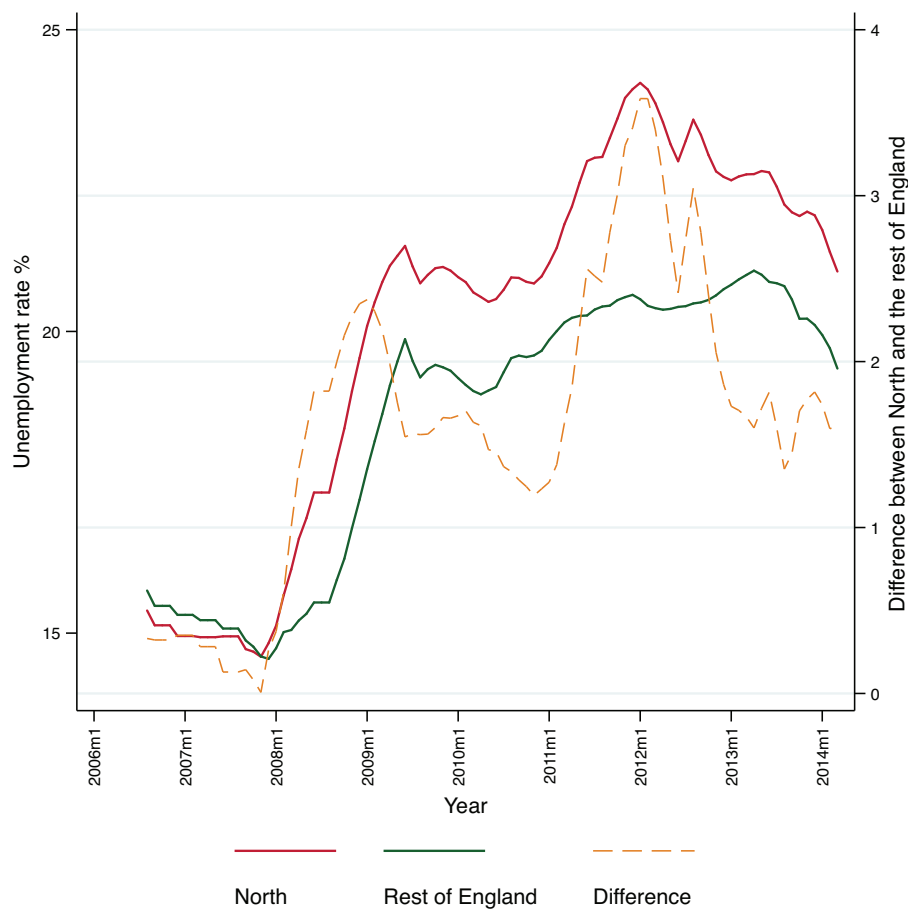
Source: ONS.

Of particular concern are the high levels of unemployment amongst young people. With the onset of the recession in 2008 youth unemployment increased rapidly. By 2011, 1 in 5 young people were out of work. The rise in youth unemployment was more severe in the North (see Figure 9). Whilst the level of unemployment amongst young people has started to fall, it is

still markedly higher than its pre-recession level and the gap between the North and the rest of England remains. The current high level of youth unemployment has serious consequences and has been described as a 'Public Health Time Bomb'³³ due to the long term scarring effects it can have on health and future employment prospects.

Figure 9: Youth unemployment rate from 2007 to 2014

Graph shows how the gap in youth unemployment, between the North and the rest of England has widened since the 2008 recession.



Source: ONS - 12 month moving average.

Falling wages, increasing wage inequality

For those in employment in the North wages are markedly lower and the gap between the North and South has widened. However this does not mean that families on low incomes in London and the South East have necessarily experienced greater improvements in living standards.

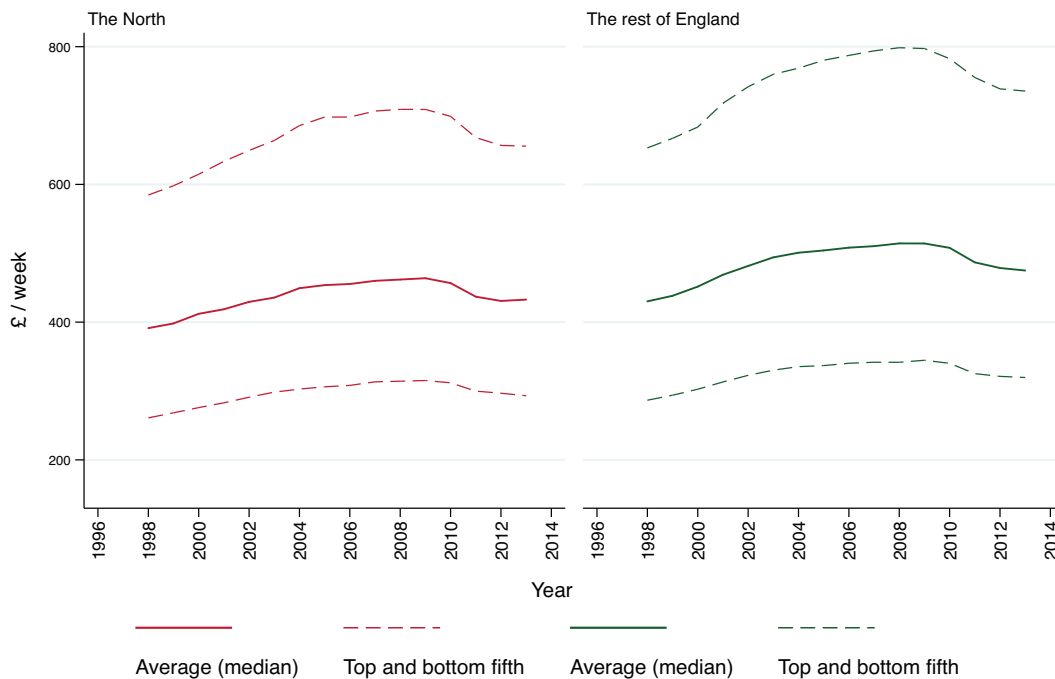
Inequalities within all regions have increased.

Figure 10 shows the trend in average wages and

the wages of the top and bottom fifths in the North and in the rest of England. There has been little real terms growth in wages for people on low incomes regardless of where they live. This growth in wage inequality during a time of economic growth has been followed by a consistent fall in real wages since 2009, the longest period of declining wages for at least 50 years.

Figure 10: Growth in median weekly earnings and top and bottom fifth percentiles, 1996 to 2012

Graph shows how wages are lower in the North, inequalities have increased across the country and wages have fallen for all groups since 2009.



Source: ASHE, gross weekly wages, full time workers - adjusted for inflation using CPI. Percentiles estimated as weighted average of regional values.

The impacts of welfare reform

A number of current reforms to the welfare system have the potential to widen the gaps in prosperity between the North and the rest of England and exacerbate inequalities within the North. The biggest financial impacts are on people with disabilities - it is estimated that individuals adversely affected by the incapacity benefit reforms can expect to lose an average of £3,500 a year, and those losing out as a result of the changeover from Disability Living Allowance to Personal Independence Payments by an average of £3,000 a year.¹³ Given that the number of people on these benefits in the North of England is much higher than in the rest of England, it is clear that these reforms will disproportionately affect the North. The higher reliance on benefits and tax credits in deprived areas in the North of England means that the failure to up-rate with inflation and the reductions to tax credits will also have a greater impact here.¹³ The under-occupation charge or 'bedroom tax' cuts an average of £14 a week from a household with one spare room. The higher numbers of people relying on housing benefit in the North will mean that more people are affected. One survey has found that two-thirds of households affected by the bedroom tax have fallen into rent arrears since the policy was introduced in April, while one in seven families have received eviction letters and face losing their homes.³⁴

Increasing poverty gap

Lower wages, higher levels of unemployment, disability and economic inactivity in the North all result in higher levels of poverty. 18% of individuals in the North East, 17% in the North West and 19% in Yorkshire and Humber are in poverty as compared to 12% in the South East.³⁵ Rates of poverty are higher in the North for both people in and out of work. Of particular concern for the North-South divide is that the gap in levels of poverty between the North and the rest of England is increasing, with rates of in-work poverty rising particularly rapidly in the North (see Figure 11). The rise of in-work poverty has become a major national concern, for the first time the majority of households in poverty in Britain have at least one person working. For many, work is no longer the route out of poverty, that it once was.³⁶ The high levels of poverty amongst those in work mean that the Government's poverty reduction strategy is unlikely to be effective, as it relies largely on people being lifted out of poverty by entering employment.³⁷

The rise of in-work poverty has become a major national concern, for the first time the majority of households in poverty in Britain have at least one person working.

Figure 11: % of working age people (16-64) in out of work and in work poverty

Graph shows how the gap in poverty between the North and the rest of England is widening.



Source: HBAI. Poverty calculated as % below 60% of 2010 median income. Poverty rates are 3 year moving average - 16-64 year olds.

It is not just low incomes that contribute to poverty, low income households also have to pay the highest charges for basic utilities such as gas and electricity (the ‘poverty premium’). Save the Children has calculated that this annual ‘poverty premium’ can amount to more than £1,280 for a typical low-income family. The poverty premium for families on a low income has increased significantly since 2007 and the cost of gas and electricity is still a major contributor to this inequity.

Food poverty is becoming an growing issue in the UK.³⁸ A recent report commissioned by the Government on household food security³⁹ concluded that organisations providing food-aid

are consistently reporting increases in demand, and there was no evidence that this was the result of increased provision of food aid as had been suggested by the Work and Pensions Minister.⁴⁰ One major food bank provider has reported a 170% rise in activity in the last 12 months.³² The primary reasons reported for this rise in use of food-aid are benefits sanctions, delays in welfare payments, crises in household income due to low wages, rising food costs and increasing household debt.³²

The burden of debt

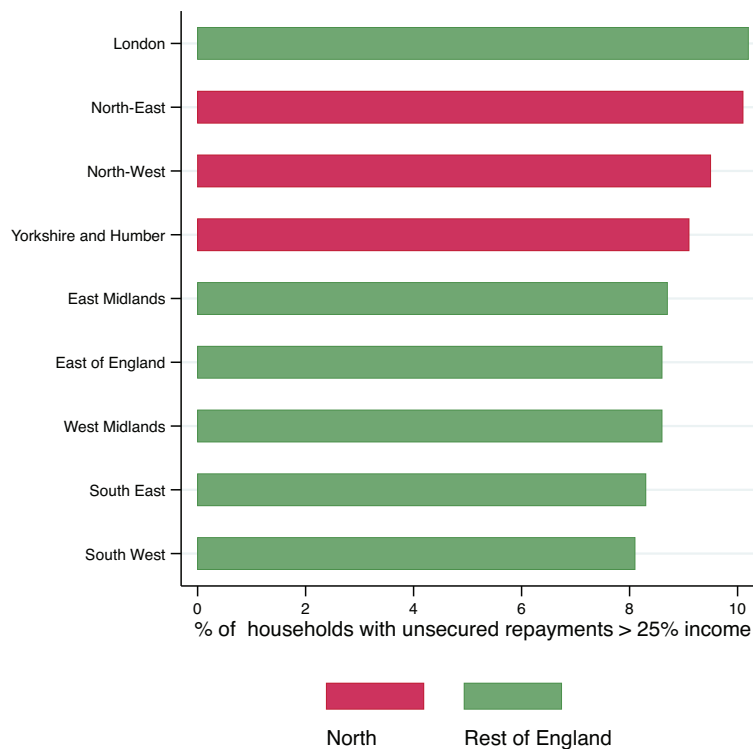
The economic growth of the past decade has been fuelled by a massive growth in personal debt. Indeed it was the high risk lending to households unable to repay their debts that brought the financial system to a standstill. The level of personal debt has nearly doubled in the past decade. People in the UK now owe £1.43 trillion, an average of £54,000 per household, up from £29,000 a decade ago. Unsecured consumer debt has trebled since 1993, reaching £158 billion in 2013.⁴¹ These debts are increasingly a problem for households on low incomes, with those on incomes of £13,500 or less having total debts worth 6 times their income.⁴² Falling wages, rising

food and energy costs, coupled with reductions in welfare benefits are contributing to increased financial exclusion and unsustainable debts.⁴³ Outside of London the Northern regions have the highest proportion of households who are spending more than 25% of their income on unsecured debts⁴⁴ (see Figure 12).

Debts are more likely to become a problem for people on low income, not just because of their inadequate income levels, but also because of the high cost of the credit services open to them such as: rent-to-own stores, doorstep lenders (home credit companies), pawnbrokers, catalogues and payday loans.

Figure 12: Percentage of households across English regions with unsecured repayments that are above 25% of their income

Graph shows how people in the northern regions have high levels of unsecured debts.



Source: Bryan, M et al. 2010 *Over-Indebtedness in Great Britain*.

The condition of housing and fuel poverty

Housing and neighbourhood conditions are important social determinants of health inequalities, with 26% of houses in the most deprived areas failing to meet the decent home standard, compared to 17% in the most affluent areas. There have been considerable improvements in the quality of social housing in recent years, with the North having a higher proportion of social housing that meets the

decent homes standard than the rest of the country. However there remains a major issue with parts of the private rented sector particularly in poor areas. Of all tenure types it is the private rented sector which has the highest proportion of homes which do not meet the decent homes standard.⁴⁵ This is particularly an issue in the North West where over 40% of houses in the private rented sector did not meet this standard in 2011 (see Figure 13).

Figure 13: Graph showing the percentage of households not meeting decent homes standard, by region and tenure, 2012

Graph shows high levels of poor housing in the private rented sector.



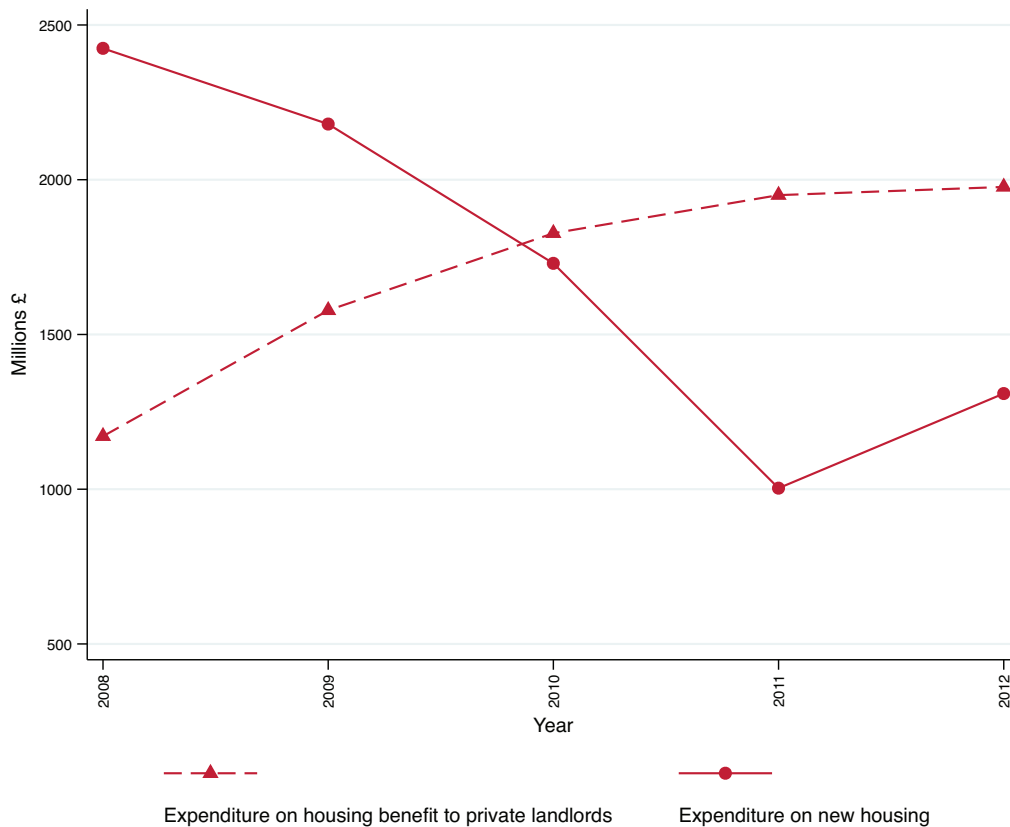
Source: English housing survey 2010

The private rented sector is also growing rapidly, increasing by 88% between 2001 and 2011.⁴⁶ This has contributed to a large increase in expenditure on housing benefits.⁴⁷ The housing benefit bill in the North of England has nearly doubled in the past 10 years from £3 billion in 2002 to £5.5 billion in 2012. The proportion of this going to private landlords increased from 10% to 15% during this time.⁴⁸ Since 2010 expenditure on housing benefits to private landlords in the North of England is now higher than the total public expenditure on building new homes (see Figure

14). It is recognised that this shift in public spending from investment in high quality affordable homes to subsidising rents in poor quality housing is not an efficient use of public resources and is not helping to address the housing problems in the North.⁴⁷ As families on low incomes increasingly have to rely on private rented accommodation, strategies to reduce health inequalities will need to implement policies that improve the quality of housing at the lower end of this sector as well as developing affordable alternatives.

Figure 14: Public expenditure on new homes and housing benefit to private landlords in the North of England 2008- 2012

Graph shows that more public funds in the North are spent on housing benefits to private landlords than on new housing.



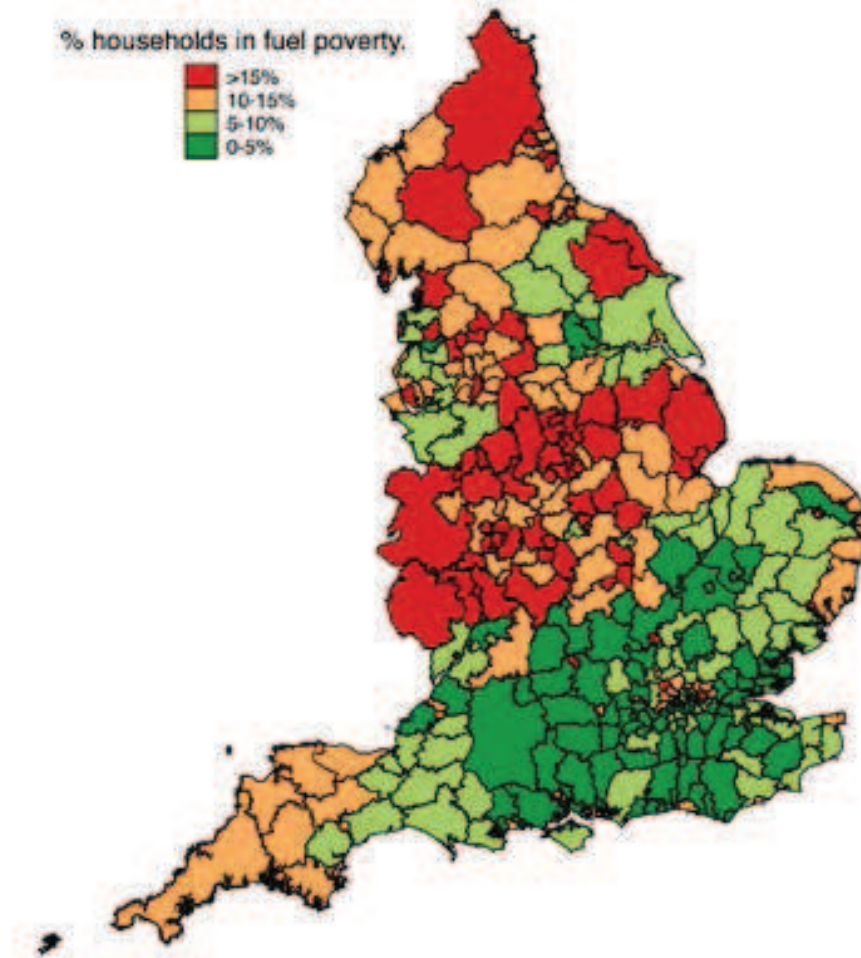
Sources: PESA and DWP.

Poor housing along with high energy bills and low incomes, all contribute to fuel poverty. In 2011, the number of fuel poor households in England was estimated at around 2.4 million, representing approximately 11 per cent of all English households.³² The poorest tenth of households spent more than a fifth of their budget on fuel

and the number of UK children living in fuel poverty has risen to 1.6 million - 130,000 more than in 2010.³² The West Midlands, North East and North West have some of the highest levels of fuel poverty in England, whilst London and the South East have the lowest (Figure 15).

Figure 15: % of households in fuel poverty, 2012

Graph shows higher levels of fuel poverty in the North of England



Source: Department for Energy and Climate Change. Low Income High Costs (LIHC) definition of fuel poverty.

How unequal economic development and poorer living conditions contribute to health inequalities

One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher debts in the North, all of which adversely impact health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health.⁴⁹ Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England.^{50,51} The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community.⁵² Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course.^{53,54}

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental

and physical health problems.⁵⁵ A number of studies have shown that psychosocial conditions at work increase the risk of health problems, in particular cardiovascular conditions and mental health problems. This has been found to explain a large proportion of inequalities in health between social groups.⁵⁶⁻⁵⁸ More precarious forms of employment including temporary contracts are also increasing and these have been associated with increased health risks.⁵⁹

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes⁶⁰ For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.⁶¹

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties.⁶² In terms of physical health, debt has been linked to a poorer self-rated physical health,⁶³ long term illness or disability,⁶² chronic fatigue,⁶⁴ back pain,⁶⁵ higher levels of obesity and worse health and health related quality of life.⁶⁶

What could be done differently?

A new approach is needed to prevent the causes of economic inequalities and poverty in the North of England. This needs to involve a long-term plan to transform how the £136 billion of public money that is spent in the North each year is used to promote the well-being and capabilities of people in the North. At present 40% of this money is spent on mitigating the effects of poverty and inequality through the provision of welfare benefits. Clearly the

provision of adequate welfare benefits for people who are unable to work due to unemployment, disability or old age is of central importance for reducing poverty. But over the long term, investing public resources in the development of people (e.g. in their education, skills and health) and places (e.g. in good housing and infrastructure) will be a more effective and efficient use of resources, promoting prosperity and reducing inequalities in the future. Prevention is better than treatment. Public service reform and economic development are therefore interlinked. Better public services that focus on developing people and places and preventing poverty result in a healthier, more skilled population which in turn helps to make the region prosperous, increasing the public resources available through taxation that can be invested in public services.

Investing public resources in the development of people and places will be a more effective and efficient use of resources, promoting prosperity and reducing inequalities in the future

The evidence reviewed by the panel has outlined a number of actions that have the potential to address these causes of economic inequalities and poverty that underlie health inequalities, whilst ensuring adequate social protection for those who need it. Firstly, there are actions related to national and regional economic strategy and investment. Secondly, there are approaches that could improve employment prospects. Thirdly there are actions to raise the standard of living of those people in and out of work; fourthly proposals to reduce problem debts, and finally actions to improve housing conditions. Evidence and analysis supporting actions in each of these areas is outlined below.

Economic strategy and investment

To address the regional imbalances in the economy of England and the inequalities within the North, the economy of the North will need to grow at a faster rate than the rest of the country, whilst ensuring the proceeds of growth are shared more equitably within the North. Growth in the North needs to be based on retaining and developing the assets of the North. This means people, skills, talent, culture, arts and the environment and not just industry. The Adonis and Heseltine reviews propose similar solutions to the regional imbalance in Britain's economy. These include greater investment in infrastructure, developing skills, investment in research, increasing investment in small to medium sized enterprises (SMEs) and crucially devolving power and resources to cities and regions. This is echoed by the early

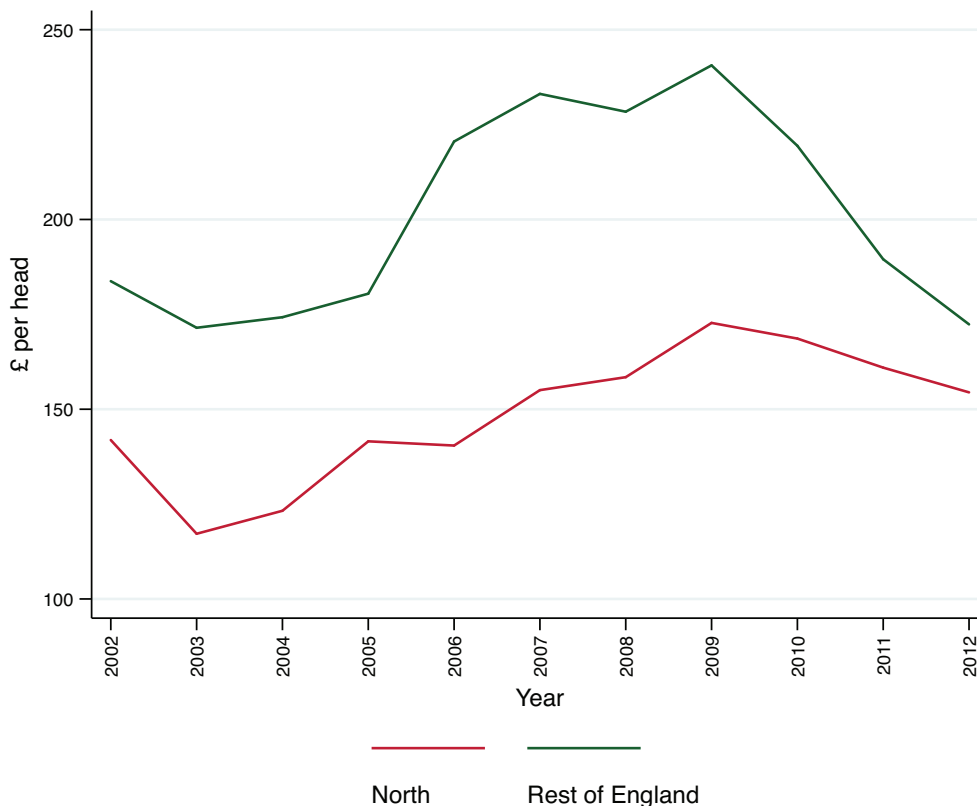
thinking of the RSA's City Growth Commission.⁶⁷ It is recognized that decisions about infrastructure, skills and investment are best made locally if they are to reflect local contexts and have a better

chance of bringing a local growth dividend, reducing regional inequalities.

The UK's infrastructure is lagging behind other developed countries and this has been cited as a major barrier to economic growth in the North.²⁸ The North currently loses out in public investment in infrastructure, which is focused on London and the South East. For example public spending on transport per head of population is markedly lower in the North compared to the rest of England (see figure 16). The imbalances in public investment exacerbate regional economic inequalities and the North will need to secure greater public and private investment in infrastructure in order to reduce these inequalities.

Figure 16: Government capital expenditure on transport per head of population in the North and the rest of England from 2002 to 2012

Graph shows lower levels of investment in transport infrastructure in the North of England.



Adjusted for inflation using GDP deflator, Source: PESA.

Increasing investment and devolving additional resources to cities and regions so that they can invest in infrastructure, skills and business will not in itself reduce economic or health inequalities. Economic growth in the major cities in the North has tended to be characterised by increasing inequalities as it has the rest of England. To reduce economic and health inequalities these need to be embedded as a core objective of economic strategies.²⁵ Some industries will be better placed than others to achieve these objectives and this should guide where local and central governments intervene to promote growth.⁶⁸ Economic models that integrate social objectives are possible and

increasingly being pursued through strong local leadership.

Governments are increasingly realizing that economic growth needs to be about more than just increased economic output. A number of governments, following the work of Joseph Stiglitz,⁶⁹ have begun to develop indicators of well-being, sustainability and equity as measures of economic progress, that can be used alongside more traditional measures such as GDP. However for these programmes to be effective, they must be aligned to policy-making and address inequalities as well as just monitoring average improvements in well-being.

Promoting good employment

It is crucial that economic growth generates good employment for all. An important mechanism to achieve this is to ensure that the money spent by the public sector on services in the North of England is used to achieve social benefits including a skilled and strong labour market. Procurement processes can be used for this purpose and the Social Value Act provides some mechanisms to support this.

With higher youth unemployment in the North of England, action to develop the skills and employment opportunities of young people is essential to address inequalities. Ineffective school-to-work transitions for those young people that do not go to university has been identified as a problem that is increasing youth unemployment.²⁸ This has led to calls for an increase in technical apprenticeships to develop the skills that are needed by employers.²⁸ Whilst there has been a large increase in apprenticeships in recent years, there has not been sufficient growth in the technical subjects needed by employers. The public sector has been criticized for being significantly underrepresented in apprenticeships, despite having the requisite roles.²⁸ The public sector remains a large employer in the North of England and should be leading the way in expanding the number of apprenticeships available in the required technical fields.

Return-to-work programmes can mitigate the health effects of unemployment as well as improve employment prospects

There is potential to build a far more integrated system locally, that joins up schools, vocational training, apprenticeships and employment support to ensure that young people are given the best chance to develop the skills they need to get a

good job, particularly those young people who don't go to university. This would involve giving local areas greater control over resources administered by the Skills Funding Agency, so that they can shape further education and training provision and apprenticeships to support local economic priorities and sectors now and in the future. Public sector partners along with private sector employers can then maximise the opportunities for training through apprenticeships. Better integrating vocational training into employment support programmes such as the Work Programme would further improve employment prospects for those out of the labour market.

Current welfare reforms have been justified on the basis that they will improve financial work incentives and this will encourage more people into work. However the evidence base indicates that reducing adequacy and access to benefits is not an effective approach to help people into employment, particularly for people with disabilities, the main cause of economic inactivity in the North.^{70,71} The evidence is stronger for active labour market policies such as return-to-work programmes. Research has shown that return-to-work programmes can mitigate the health effects of unemployment as well as improve employment prospects, particularly those that involve training and increased social contact and support.⁷² However there is also evidence that some return to work programmes can be more harmful than unemployment on its own.⁷³ The

evidence indicates that effective approaches use integrated case management to combine vocational training, rehabilitation and involve employers in return-to-work planning. They provide long-term, sustained and staged support for those furthest from the labour market and address underlying health issues alongside other barriers to employment.⁷⁴⁻⁷⁷

The Government's flagship active labour market policy, the Work Programme, has been criticized for poor performance and in particular failing people with disabilities. Only around 2-4% of the clients on disability benefits referred the programme have found work after a year, a figure that is worse than the programme it replaced.^{78,79} The payment by results model of the Work Programme exacerbates inequalities, as it means that the service is more profitable for providers working in the areas with the best labour markets.⁷⁸ Several organisations have called for a localisation of return-to-work programmes⁸⁰ such as the Work Programme, which are currently centrally commissioned by the DWP. This would enable these programmes to better link with skills and training, local employers and integrated support across the public sector including the NHS: a model that better reflects the evidence base for

effective approaches. An example of how such localisation might work is Greater Manchester's 'Working Well' programme, which was launched in March 2014 and will run for 5 years. It will support 5,000 Employment and Support allowance (ESA) claimants across Greater Manchester to overcome their barriers to work. Under the scheme, individuals will receive integrated and intensive support from key workers, who will coordinate public services to ensure issues which are holding claimants back from work are tackled at the right time and right order. Central government is providing 80% of the funding for the pilot, with the remaining 20% made up by the ten Greater Manchester local authorities.

Raising living standards

The evidence presented to the panel outlined a number of promising approaches to raising the standard of living of those people in and out of work on low incomes. Firstly there are approaches to extend the Living Wage. Since

2010, several local authorities, including Blackpool, Islington, Liverpool, Newcastle, Sheffield, Newport, Plymouth, Southampton, Leicester, Tower Hamlets and York have established 'Fairness Commissions' to investigate and implement ways of reducing inequality in their areas and have recommended implementing and campaigning for the payment of a Living Wage.⁸¹ The recent report of the Living Wage Commission has concluded that bringing an additional 1 million workers up to the Living Wage is achievable by 2020. They outline a roadmap of recommendations to achieve this, including, ensuring that all directly employed public sector employees are paid a Living Wage and that the public sector considers whether contractors pay a Living Wage when procuring services.⁸²

To reduce health inequalities benefits need to be set at a level that ensures health is not adversely affected.

A Living Wage even if widely implemented is however only part of the solution. Being out of work continues to carry a much higher risk of poverty than being in low-paid work. Current changes to the level of welfare benefits are being justified on the basis that they will improve financial work incentives. However to reduce health inequalities benefits need to be set at a level that ensures health is not adversely affected. The evidence-base for a Minimum Income for Healthy Living (MIHL) has established a benchmark for the level of income that enables consumption of a healthy diet, expenses related to exercise costs, as well as costs related to social integration and support networks.⁵⁵ The MIHL provides a systematic approach to setting welfare benefit levels, so that they effectively counteract poverty, improve living standards and reduce health inequalities. This led the Marmot review of health inequalities to recommend that standards for minimum income for healthy living were developed and implemented.

Reducing debt

There is a growing recognition that credit unions can have a positive influence on the financial capability and hence the well-being of their members, particularly in low-income areas.⁸³ They have the potential to provide more secure access to credit for people on low incomes by addressing the power imbalances between creditor and debtor that characterize the current pay-day lending market. As democratic organisations credit unions are more likely to work in the interests of their members particularly those that have poor financial capability. However a study by the DWP found that the credit union sector would need to overcome a number of weaknesses to fully realise its potential.⁴² A recent report by the IPPR has proposed a strategy for overcoming these weaknesses and expanding local not-for profit institutions such as credit unions. They propose establishing an Affordable Credit Trust (ACT) – a statutory body that would expand access to affordable short-term credit provided by non-profit-making, member-owned and democratically run institutions. This would be achieved by the ACT issuing ‘charters’ to these institutions based on a set of minimum conditions, providing them with capital, enabling risk sharing between institutions, and monitoring and supporting their work.⁴²

The case for the introduction of a cap on the cost of credit in the UK was previously explored by the Office of Fair Trading (OFT) in its review of high cost credit.³² There is a need to limit the cost of credit to low income households through properly enforcing current legislation and potentially developing new legislation to cap either the interest rate or total cost of credit (the total amount paid, including interest and other charges such as compulsory insurance). Whilst there is concern that this would reduce

credit opportunities for low income customers, who potentially would turn to illegal money lenders, research has shown that a cap on interest rates can protect low income consumers without negative impacts.⁸⁴

Improving housing

Improving housing conditions, making homes warmer, affordable and reducing fuel poverty in the North of England would reduce health inequalities.⁶⁰ As noted above, there have been large improvements in the condition of social housing. Between 2000 and 2010 the Decent Homes Programme improved the housing condition of over a million households in social housing. Registered Social Landlords (housing associations, trusts and cooperatives) were particularly effective, reducing the percentage of their non-decent homes from 21% to 8%. The majority of these homes were improved at no direct cost to the taxpayer.⁸⁵

Between 2003 and 2011 the government implemented a Housing Market Renewal (HMR) programme to tackle problems of poor housing in areas of intense deprivation, largely in northern inner cities and towns. £2.2 billion was invested directly through the programme, and more than £1 billion additional investment came from other partners. The National Audit Office concluded that the achievements of this investment were considerable, improving the quality of the housing stock, reducing crime as well as increasing jobs and training opportunities in the implementation areas.⁸⁶ Others have criticised the HMR programme for insufficiently engaging with local communities.⁴⁷ The cessation of the HMR programme in 2011 has led a number of local authorities to look for new approaches to address underlying problems in the housing market.

Public expenditure on housing has fallen considerably since the recession and it is unlikely that this trend will reverse in the near future.⁸⁰

Therefore new sources of finance are needed to improve housing conditions in the North of England. In Scotland Alex Salmond has called for pension fund investment in a major house building programme, and local authorities in England have begun to consider similar schemes.⁸⁷ For example in Greater Manchester the Housing Investment Board is developing new approaches to promote investment in affordable housing including using public sector land and investment from local authority pension funds.⁸⁸ There is a need for local areas to shift from 'benefits to bricks', in other words to be able to build more affordable high quality homes which would save money over the long term by reducing local housing benefit spending. This has led some to call for councils to be allowed to retain and reinvest a share of any savings achieved by local action to reduce housing benefit levels.⁸⁰ Others have highlighted that housing policy is overly centralised indicating that decentralizing funding to regional funds could enable public resources to more efficiently meet housing needs.⁴⁷

As well as increasing the amount of affordable housing in the North there is a need to improve the condition of the private rented housing particularly at the low end of the market. This has led to a third of councils in England considering proposals for the compulsory licensing of private landlords in some areas to improve housing conditions.⁸⁹

3.3 Development in early childhood

Disturbing trends

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe.^{90,91} Within the UK the health of children is generally worse in the North, reflecting higher levels of child poverty (see Figure 17).

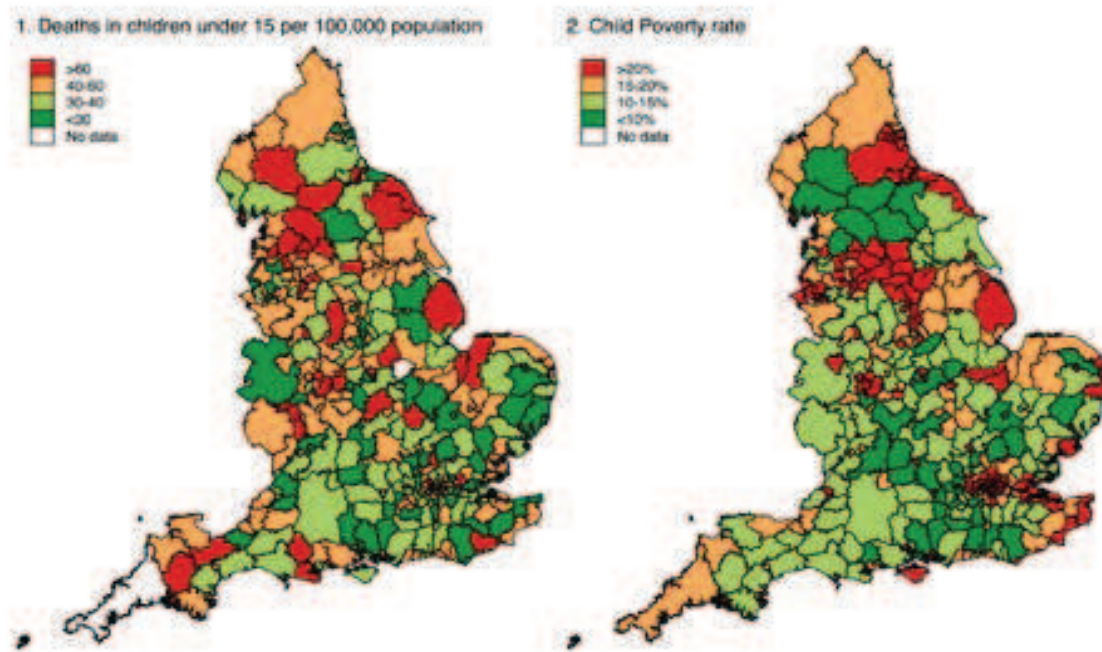
There is a large body of evidence demonstrating that early disadvantage tracks forward, to

influence health and development trajectories in later life, and that children who start behind tend to stay behind. For example, children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.⁹²

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have

Figure 17: Child poverty rate and under 15 year old mortality per 100,000 population by local authority area in England

Map shows higher levels of child poverty and mortality in the North of England.



Sources: 1. HSCIC. 2. HMRC - Children in families receiving WTC and CTC, and income <60% median.

repeatedly shown that providing better support early in children's lives is one of the most effective approaches to reduce inequalities in life chances. As the Marmot review of health inequalities in England concluded:

'Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.'

In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

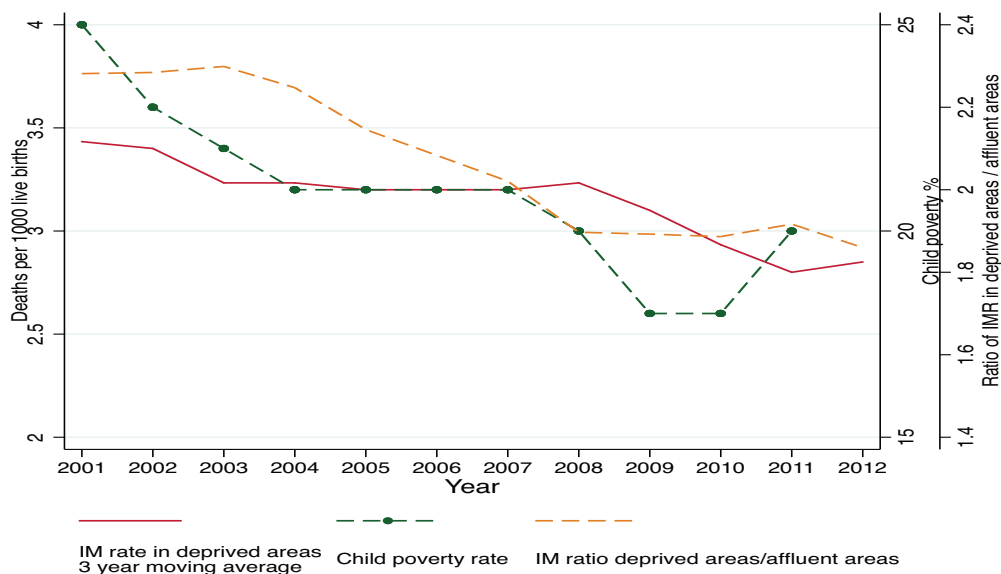
Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities.⁹³ In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty.⁹⁴ In order to address these targets a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this time (see Figure 18). However we are now seeing signs that these achievements are being undone.⁹⁵ For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant

mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.⁹⁶

For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011

Figure 18: Reduction in inequalities in Infant Mortality (IM) and child poverty from 2001 to 2008, and trends following recession to 2012

Graph shows reduction in inequalities in infant mortality and child poverty



Source: 1. HSCIC. 2. HBAI, poverty rate defined as 60% of 2010 median income.

Recent analyses of austerity policies in the UK suggest that children are amongst the groups being hit hardest.⁹⁷ A number of the changes to the welfare and benefits system have been detrimental to children, including the abolition of the education maintenance allowance, health in pregnancy grants and child trust funds, the freezing of child benefit, the removal of working tax credit from couples working 16-24 hours, and the failure to uprate child tax credit with inflation.⁷⁹ Spending on children's centres has fallen by 28%, 580 children's centres have closed and local government spending on early childhood development programmes has fallen by £28 per person.⁹⁸ The largest cuts to children's services are however yet to come, with a number of councils in the North of England announcing further drastic cuts to children's centres, following the 2015/16 local government finance settlement. For instance Liverpool City Council announced

proposals to cut the children's centre budget by 70%, reducing the number of centres from 27 down to 3. Sheffield's 36 Children's Centres are being re-organised into 17 hub centres and Rotherham Council has proposed to close 13 of its 22 Children's Centres.⁹⁸ This level of disinvestment from support for early years interventions is likely to increase health inequalities and the gap in health outcomes between the North and the rest of England.

How insufficient investment in early child development contributes to health inequalities

The benefits of investing in the early years are well demonstrated. Investing in improving the life chances of children in the North of England will reduce inequalities in the North and between the North and the rest of England. Disinvesting in children will increase these inequalities. The repercussions of not providing high quality support early in children's lives are severe, not just for the health of children, but also for the sustainability of public services in the future. Tackling many of life's inequalities at the earliest age yields improvements across

the life-course, which in turn can result in large financial savings.⁹⁹ The Nobel Prize-winning economist James

Heckman has set out a compelling economic case that shows that the rate of economic return on early year's investment is significantly higher than for any other stage in the education system. Heckman states that investment in the early years is 'a rare public policy initiative that promotes fairness and social justice and at the same time promotes productivity in the economy and in society at large'¹⁰⁰ Shifting resources significantly to support the early years of life has the potential to not only impact on the health divide but also could help reduce the economic divide as well.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the

health and well-being of children has the potential to engender a new commitment to investment in the early years.

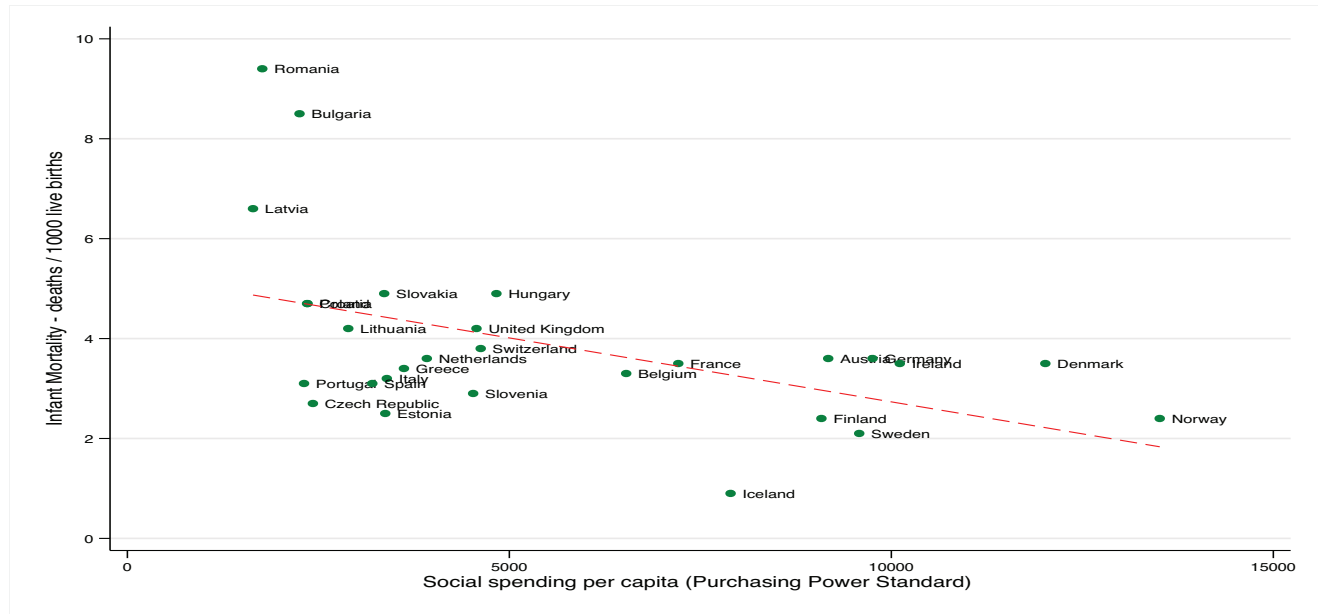
Actions to promote healthy development in early childhood need to address the immediate issue of children living in poverty today, whilst investing in the early years to prevent poverty in the future. This requires two strands of action. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Secondly, universal early years education, childcare and integrated neighbourhood support for early child development is needed to break the link between parental poverty and a child's life chances.

Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises.

Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises.^{101,102} Those countries in Europe that do have more adequate social protection experience better child health outcomes (see Figure 19). The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Figure 19: Social welfare spending on families and children and infant mortality in 27 EU countries - 2011

Graph shows how greater levels of social spending are associated with improved child health.



Source: EUROSTAT.

Income transfers alone, however, are not a sustainable approach to reduce poverty and inequalities in child health.¹⁰³ A system of high quality universal early years child care and education support is also necessary. In Nordic countries the links between a child's life chances and that of their parents are weaker than in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.¹⁰⁴

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across the gradient would effectively reduce inequalities. Providing any education is not enough, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects¹⁰⁵

Considerable progress has been made over the

past 2 decades at increasing the level of public investment in early years childcare and education. Current levels of free entitlement benefit almost all families with young children and the evidence indicates that this is making the most difference to children from disadvantaged backgrounds.¹⁰⁶ Families are currently entitled to 15 hours of pre-school childcare for 3-4 years old, 38 weeks a year. The current Coalition Government has extended this to 2 year olds for the most deprived 20% of families and this will be widened to the most deprived 40% of families from September 2014. However this offer is restricted and will still limit parent's employment opportunities. A universal entitlement ensures that all families have a stake in childcare provision, this engenders popular support for childcare and promotes sustainability. Analysis indicates that extending the universal free entitlement of early years child care and education to 15 hours a week for 48 weeks per year, for all children from the age of

two until they enter school, and guaranteeing an additional 20 hours of subsidised childcare a week for working parents, would increase maternal employment and improve child development.¹⁰⁶ Analysis by IPPR indicates that with government subsidising 95% of the costs of these additional hours for families on Universal Credit and 30% for other families, this extension of early years provision could be affordable through changes to the marriage tax allowance, child benefit and tax relief on pensions.¹⁰⁶

This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities.¹⁰⁷ The evidence base for these early interventions is strong, and has been extensively reviewed elsewhere.^{108,109} It is vital that these interventions are sustained over the long term and supported by sufficient investment. As the review of child poverty by Frank Field has recommended government should be gradually moving funding to the early years and this should be weighted to the most disadvantaged areas.¹⁰³

3.4 Devolution and democratic renewal

Disturbing trends

Amartya Sen, the Nobel prize winning economist has concluded that a fundamental cause of inequalities in health is the relative lack of control and powerlessness of less privileged groups.¹¹⁰ According to the Marmot review of health inequalities in England⁵⁵, strategies to reduce health inequalities should 'create the conditions for people to take control over their lives...the review puts empowerment of individuals and communities at the centre of actions to reduce health inequalities.'

People need to have resources in order to have control over the environment in which they live and the decisions that affect them. So the proposals outlined to tackle poverty and economic inequality, fairly distribute resources and invest in early child development are all essential to promote greater control. Ensuring that all people have adequate resources to participate in society is good for society as a whole not just those who are disadvantaged. More equal societies work better for everyone, whatever their social position.¹¹¹

How resources are used, and how fairly they are distributed depends in part on the control and influence of different social groups. Those societies that have stronger democratic institutions, where disadvantaged groups have more control and influence tend to have fairer distribution of resources. Addressing the inequalities in power and resources that underlie health inequalities involves influencing those who have the power to make a difference and increasing the power of those who are powerless.

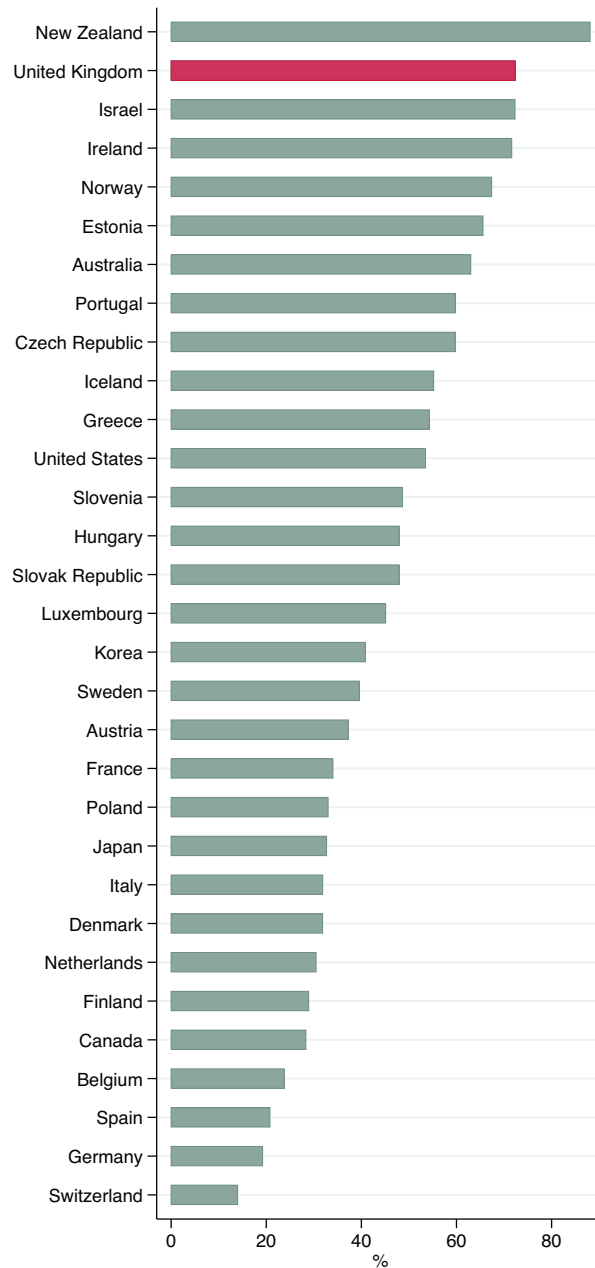
Devolution and democratic renewal are therefore

central for addressing health inequalities within the North and between the North and the rest of England. Devolution means regions in the North retaining more power and resources to collectively develop solutions that build on the assets and resilience of the North. Democratic renewal means people in the North having greater influence over how resources are used and the decisions that affect their lives. Democracy is not just about voting. Although representation is important, increasing the influence people have also requires greater participation (direct mechanisms through which citizens can influence decision making) and deliberation (developing decisions through public debate and reasoning of the alternatives and their consequences).

The UK has one of the most centralised political systems in the OECD.¹¹² Figure 20 shows the proportion of government expenditure in each OECD country that is controlled by central government, rather than sub-national levels of government. In more centralised countries political institutions may appear unrepresentative and distant. European countries that have stronger local government tend to have higher turnout in elections,¹¹³ potentially reflecting that government is more in touch with the day-to-day problems that people face.¹¹⁴

Figure 20: Proportion of total government expenditure controlled by central government, OECD countries, in 2009

Graph shows how the UK has one of the most centralised governments in the OECD.



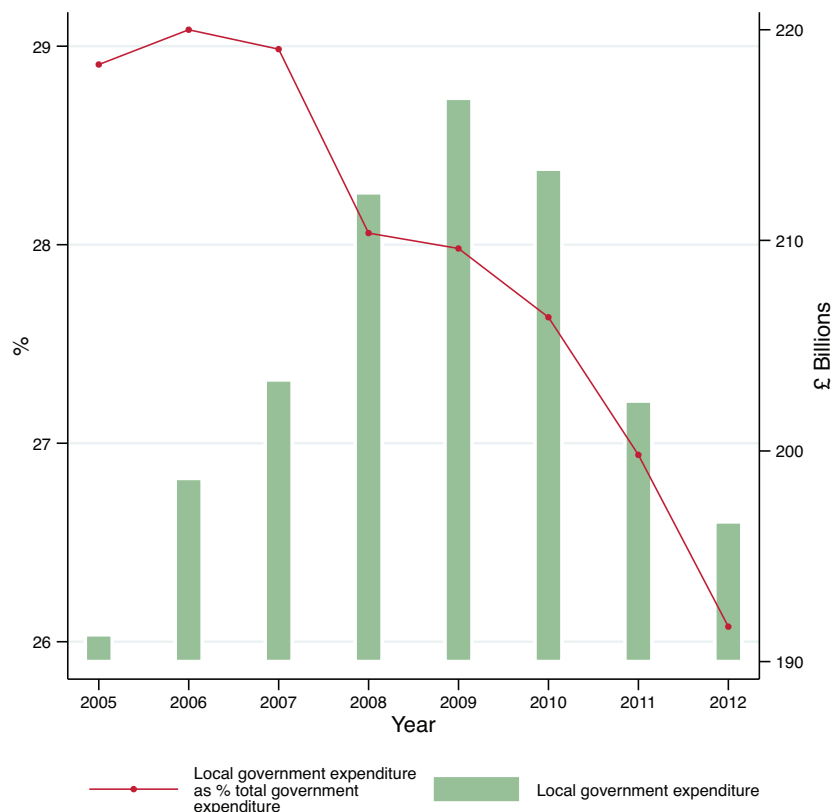
Source: OECD-Government at a Glance 2011.

Whilst both the current and previous governments have promoted localism, the rhetoric of public policy is often different from the reality. Government in the UK continues to become more centralized. Local government expenditure as a proportion of total public expenditure has been declining for a number of years and recent austerity measures are exacerbating this (see Figure 21).¹¹⁵ Since 2010 local government has received some of the largest cuts to their budgets an average reduction of around 33%, compared to a 12% reduction in other government departments.¹¹⁶ (see Figure 21).

The centralised nature of government in the UK limits the capacity for local governments and regions in the North to take action to really make a difference to people's life chances. For example, of the £22bn public funds spent in Greater Manchester each year, central government controls how £16bn is spent and has significant influence on the rest. Localism and democratic engagement are therefore closely related; where power and resources are actually devolved to local areas, this has the potential to enhance the influence people have over the way their communities are run. But this will only be the case if devolution of power and resources to local administrations is accompanied by greater public participation in local decision-making.

Figure 21: Local government expenditure in England from 2005 to 2012, and local government expenditure as a % of total government expenditure

Graph shows the decline in public resources controlled by Local Government since 2005 and how this is exacerbated by cuts in council budgets.



Source: OECD Fiscal decentralisation database, adjusted to 2012 prices using GDP deflator

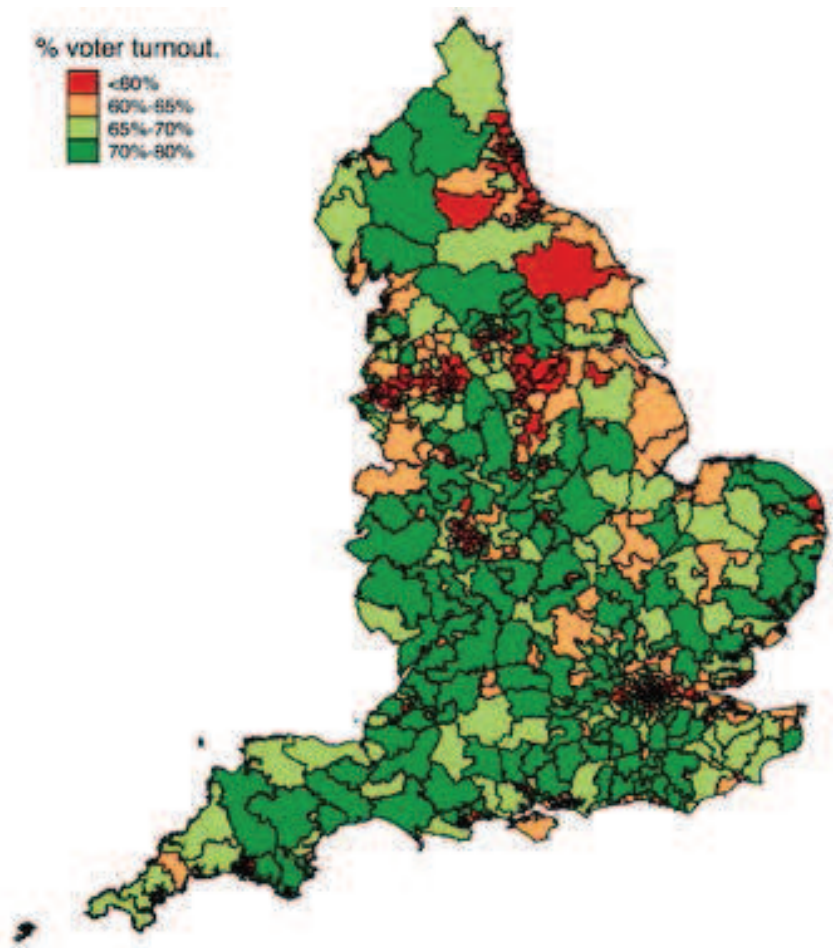
It is well recognized that democratic engagement in the UK, as in many other 'wealthy' countries has declined in recent years. But this decline is not being experienced equally across all social groups. The decline in political engagement is occurring at a faster rate in more disadvantaged groups. Political inequality and economic inequality are interrelated and the declining influence of disadvantaged groups on public policy exacerbates inequalities. For example a recent report has shown that it is those who are most

disengaged from the democratic process (and do not vote) who are being hit hardest through current changes to welfare policy in the UK.¹¹⁷

The pattern of voter turnout in England closely mirrors patterns of poverty and poor health (see Figure 22). Whilst this is only a sign of democratic disengagement it means that people living in disadvantaged places lack influence over whether and how public resources and community assets are used to improve their health.

Figure 22: Voter turnout by parliamentary constituency in the 2010 General Election

The North South Democratic Divide. Map shows the lower levels of voter turnout in poorer areas in the North of England.

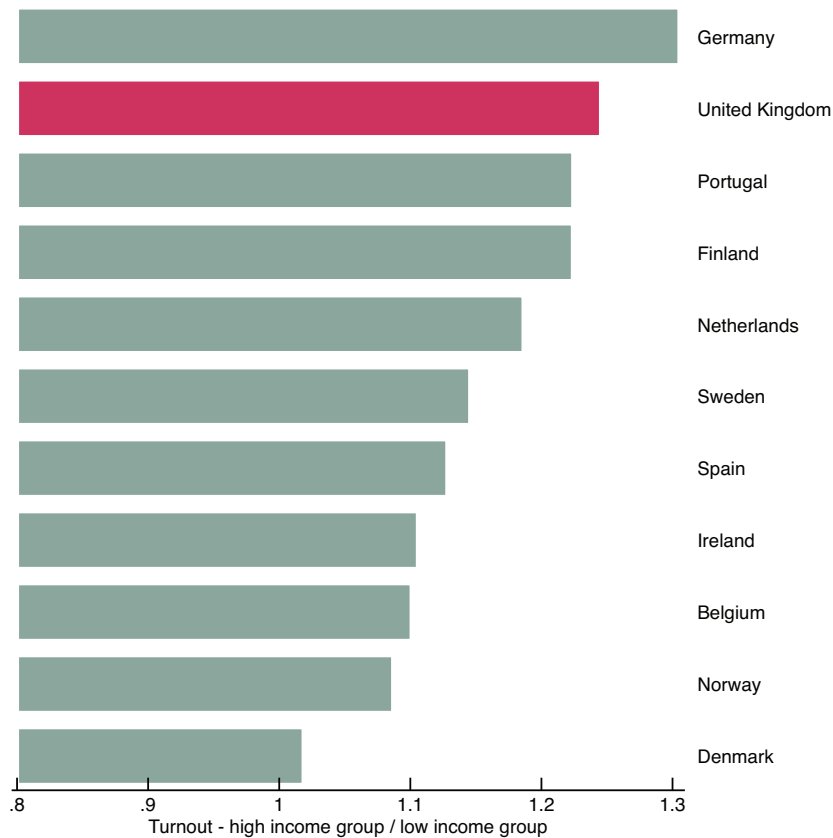


Source: Electoral Commission.

Inequalities in democratic participation are greater in the UK than many other European countries (Figure 23). A number of other measures of democratic engagement (signing a petition, discussing politics, expressing views to an elected representative, attending political meetings) are also lower in more disadvantaged groups and people living in deprived areas are less likely to report that they can influence decisions affecting their local area.^{117,118}

Figure 23: Voter turnout in high income groups relative to low income group in selected European countries – most recent election before 2012

Graph shows high inequalities in voter turnout in the UK. Ratio of the voter turnout in high income group relative to low income group.



Source: European Social Survey, 2012 – Wave 6. Includes all EU15 countries participating in the Survey. Low income - bottom quintile, high income - top quintile. Question: 'Did you vote at the last national election?' "Does not include those who were ineligible to vote at last election.

How the lack of influence and democratic engagement contributes to health inequalities

There are three ways through which levels of community control and democratic engagement have an impact on health. Firstly those who have less influence are less able to affect the use of public resources to improve their health and well-being. For example the Northern regions have had limited collective influence over how resources and assets are used in the North of England and this has potentially hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.¹¹⁸

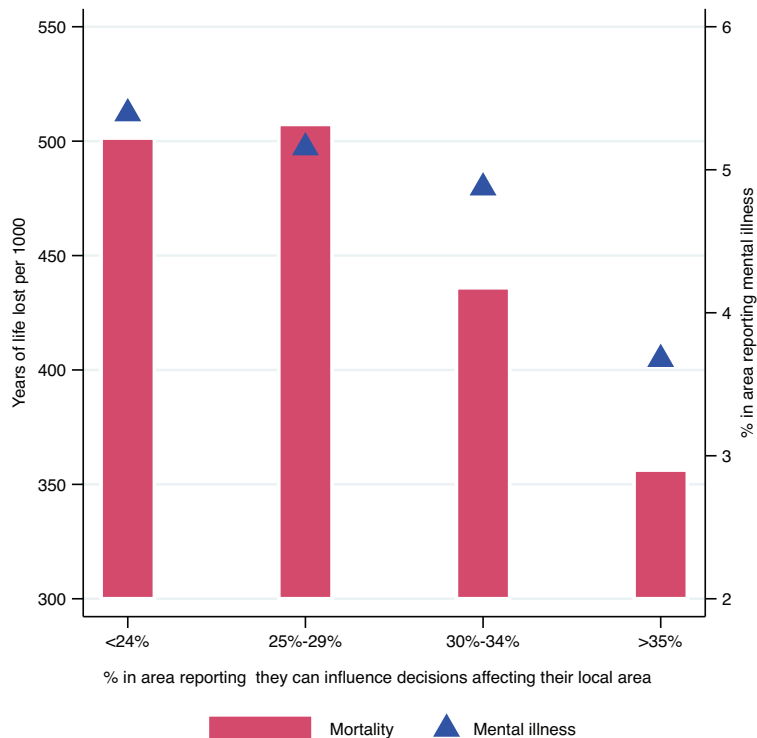
There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health.^{57,119-122} A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities.^{118,123-126} Countries with long-term social-democratic governments tend to have more developed preventive health services.¹²⁷ US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability.^{128,129} There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.¹³⁰⁻¹³⁵

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social

isolation and nurture a sense of community, trust and community competence.¹³⁶ Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment.¹³⁶ Figure 24 shows the level of mortality and mental illness amongst the 65 most deprived local authorities in England divided into 4 groups based on the proportion of the population reporting that they can influence decisions in their local area. As the level of influence increases, the average level of premature mortality and prevalence of mental illness in the area declines.

Figure 24: Average levels of mortality and mental illness split amongst four graded groups of deprived local authority areas

Graph shows that health is better in poor areas where people have more control.



20% most deprived local authorities. Sources: 1. Place Survey (2008). 2. Annual population survey (2007-2009) 3. HSCIC (2007-2009)

Concerns have been raised that devolving power to local areas, particularly where they are given greater freedom to raise funds through taxation and develop divergent systems of welfare (in health, education, housing and social protection for example), could disadvantage economically under-developed areas and result in differences between areas in the level of welfare provision. However there is limited empirical evidence to support these concerns. Regional devolution in some countries has resulted in a decline rather than an increase in inequalities between regions.¹³⁷ However this has tended to occur in countries where there are strong popular movements demanding devolution, and devolution

has occurred alongside greater democratic accountability at the regional level. It has been suggested that the greater dispersal of power in more devolved systems has actually helped prevent some of the reductions in welfare provision that are being experienced in many countries.¹³⁸

The evidence presented to the panel therefore supports the conclusions of the Marmot review of health inequalities in England that the empowerment of individuals and communities should be at the centre of actions to reduce health inequalities. Policies that enhance the democratic engagement and collective influence of the North as a whole and of the communities within the North will contribute to reducing health inequalities.

What could be done differently?

England's eight largest cities outside London, five of which are in the North, recently launched a major national campaign demanding more power over how they spend their money.¹³⁹ Northern local authorities are strengthening their ability to work together and are lobbying government for greater devolution of powers and responsibilities. The Greater Manchester Combined Authority is looking for a deal with the Government that would give it greater control over significant blocks of funding, enabling it to implement a programme of economic development and public service reform that aims to eliminate, by 2020, the current gap between spending on public services in Greater Manchester and the tax generated in the area.¹⁴⁰ The referendum on Scottish Independence is adding momentum to these demands for greater devolution for the North of England¹⁴¹ and the economic development strategies of both the Government and the opposition are also strongly focused on devolving power and resources to city and county regions (see section 4.3).

In the past, a barrier to effective action on health inequalities has been that centrally imposed constraints on services and the use of different budgets has prevented joint working across the determinants of health inequalities (e.g. education, training, employment, health, social care, and housing). For local communities and organisations to effectively shape services in an area, sufficient resources need to be controlled locally and there needs to be greater flexibility for all public service organisations to be able to co-design services, share budgets, systems of management and governance. The previous Government's 'Total Place' programme, which has been taken forward in the coalition's 'Community Budget' programme, is an approach to address this issue. This could be extended further with budgets allocated over

longer time scales to enable organisations to work with local communities and develop sustainable new approaches for integrated public services. This approach to public service reform that provides the right support at the right time, reflecting how people live their lives, rather than the organisational boundaries of public services, is needed to prevent poverty and inequalities. When people develop chronic illness, for example, integrated support across agencies to keep people in employment and maintain financial security can help prevent a downward spiral of poverty and poor health that exacerbates inequalities.

Present strategies for devolution and integration, however, say very little about how they will address inequalities or enhance democratic accountability. The international evidence¹³⁷ indicates that devolution can lead to greater public investment in welfare systems, but only if it occurs alongside greater democratic accountability at the regional level. Proposals for devolution need to develop democratic mechanisms that enhance the capacity for communities, organisations and enterprises across the North to work collectively to address inequalities. Strategies to enhance community control need to start with the issues that people face on a day-to-day basis and the services they use. The decentralisation of budgets and services could significantly enhance local democratic engagement as long as this happens alongside an expansion of the influence that local communities have over how these resources are used.

Participatory Budgeting (PB) provides a promising approach that could support this. Whilst there have been a number of small PB projects in the UK, this would need to be carried out on a large scale involving a significant proportion of public resources if it is to be effective. It needs to involve the widespread participation of residents in the deliberation and agreement of local budgets. In

Latin American Countries, PB is now used as a mainstream mechanism to allocate a significant proportion of the budget of over 1,000 local authorities, with 43% of the population in Brazil now living in municipalities with Participatory Budgets.^{142,143} The evaluation of the 5 PB pilots in the UK found that the introduction of PB increased turnout in elections, improved social cohesion, attracted additional funds into deprived areas, and improved the self-confidence of individuals and organisations.¹⁴⁴ International evidence shows that PB can produce more equitable public spending.¹⁴⁵ Although a National Strategy for PB was published in 2008 with the stated aim that PB should be used in every local authority area by 2012, there has been little progress in expanding the use of PB in recent years.¹⁴⁶

Approaches to enhance the power and control that people have over the institutions that affect their lives have tended to focus on the people themselves. However it is often the institutions that are limiting the influence that people have. The institutions (for example government, councils and providers of services) need to change to enable people to participate in, negotiate with, influence, control, and hold them to account. There is evidence indicating that where the public are involved in and have some control over services this improves their uptake and effectiveness. Community-owned social housing for example has been found to perform better than local-authority managed housing in terms of both the quality of services and community cohesion.¹³⁶ A number of national policies have been introduced in recent years that aim to enable communities to take over public services and assets. These will only enhance community control and reduce inequalities, however, if resources are invested to enable disadvantaged communities to

take on this role and if these assets are transferred to truly democratic organisations. Mutuals, cooperatives and similar types of organisations, where people using the services have a voice in their operation, have the potential to increase genuine participation of disadvantaged groups in the provision of services.¹⁴⁷

Whilst it is perhaps more important that public institutions change to enable greater participation, people do also need the skills and resources to be able to engage and influence public services. There is evidence indicating the important components of effective community engagement. Guidance issued by the National Institute of Health and Clinical excellence highlights a number of elements that should be included in approaches that seek to increase levels of engagement. These include building on established networks to recruit individuals from the local community and investing in a process of training and action to engage them with community members to influence the planning and delivery of services. It is also important to ensure that mechanisms are in place to adequately reward people for participating.¹⁴⁸

3.5 The role of the health sector

Promising and disturbing trends

Whilst the focus of this inquiry has been to develop policies that have an impact on the social determinants of health inequalities, health care systems also have an important role to play. In most international comparisons the NHS is rated favourably compared to other countries, particularly in terms of equity of access and strength of primary care¹⁴⁹ Whilst socioeconomic inequalities in access to healthcare do exist in England, the assessment of the Panel was that these were unlikely to account for the size and nature of the differences in health status that exist between the North and the rest of England. International evidence suggests that health services have made a valuable, if modest, contribution to recent declines in mortality in England and other countries. Estimates indicate that improvements in health care account for between 15% to 25% of these declines in mortality, the rest being explained by factors outside the health service.¹⁵⁰

Timely appropriate access to high quality care is more effective at preventing deaths from some health conditions (for example heart disease), than others (such as accidents). Mortality that could be preventable through action by the health service is referred to as 'mortality amenable to health care'. The risk of dying from these conditions is increased by factors outside the health service, such as the circumstances in which people live and work, but this risk can be ameliorated through high quality health care. Figure 25 shows the pattern of mortality from these 'amenable' causes across England in 2012.

The North continues to experience higher rates of mortality amenable to health care than the rest of England, with the deprived areas within the North of England experiencing some of the highest levels in the country.

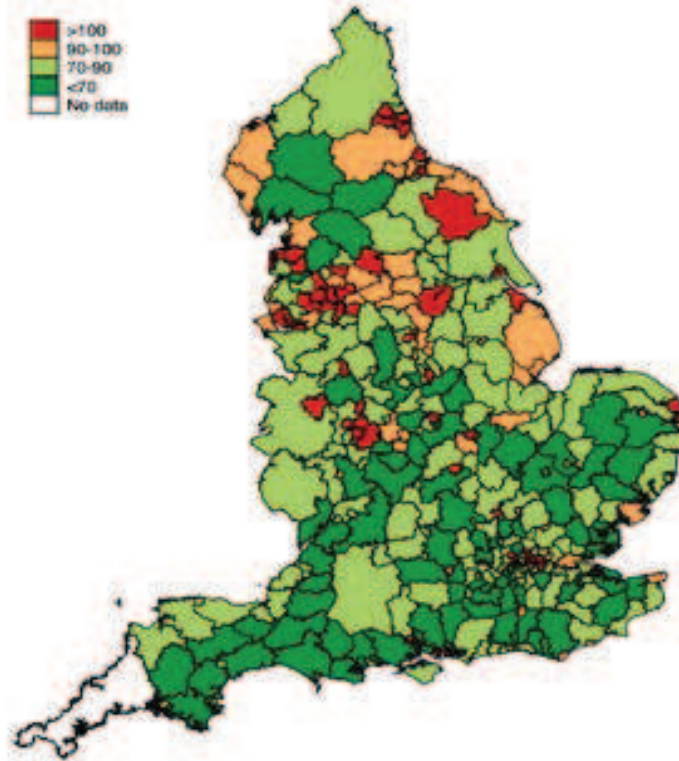
Mortality amenable to health care has been falling dramatically in recent years. This is explained by a number of different factors. These include reductions in risk factors such as smoking, increased investment in health care, and improvements in treatment. The NHS has implemented a wide range of quality improvement initiatives since the 1990s, including the establishment of the National Institute for Health and Care Excellence (NICE), the introduction of more robust clinical governance arrangements, expanding use of information technology, issuing national service frameworks for chronic conditions, and pioneering financial and reputational incentives for providers. These have contributed to rapid improvements in quality of care, particularly in primary care.¹⁵¹

The NHS is rated favourably compared to other countries, particularly in terms of equity of access and strength of primary care.

In England, these improvements in amenable mortality have been greatest in the more deprived parts of the country,²³ as a result of which the mortality gap between local authorities in the North and those in the rest of England has narrowed slightly over the past decade, particularly for men (see figure 26). A number of countries have experienced similar declines in absolute inequalities in mortality amenable to health care. This led Mackenbach (2003) to conclude that 'The introduction of effective medical care, aided by perhaps not a perfect but a nonetheless very considerable degree of access to health care for the lower socio-economic groups, has caused mortality differences to narrow, at least in absolute terms'¹⁵²

Figure 25: The pattern of mortality amenable to health care across England in 2012

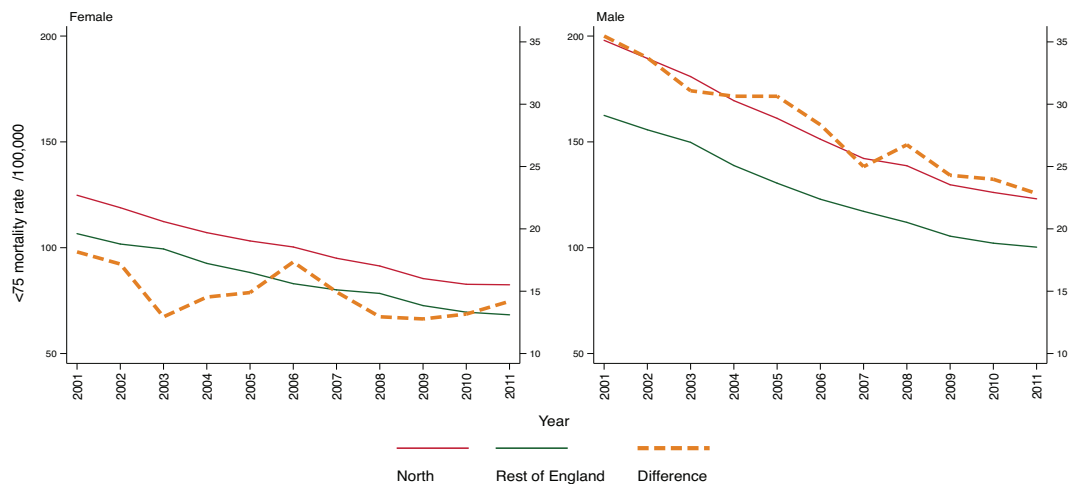
Map shows higher levels of mortality amenable to healthcare in the North.



Source: HSCIC.

Figure 26: Trend in mortality amenable to healthcare in the North and the rest of England

Graph shows how the mortality gap from causes amenable to health care between the North and rest of England has reduced.



Source: HSCIC. Population weighted averages of local authority rates

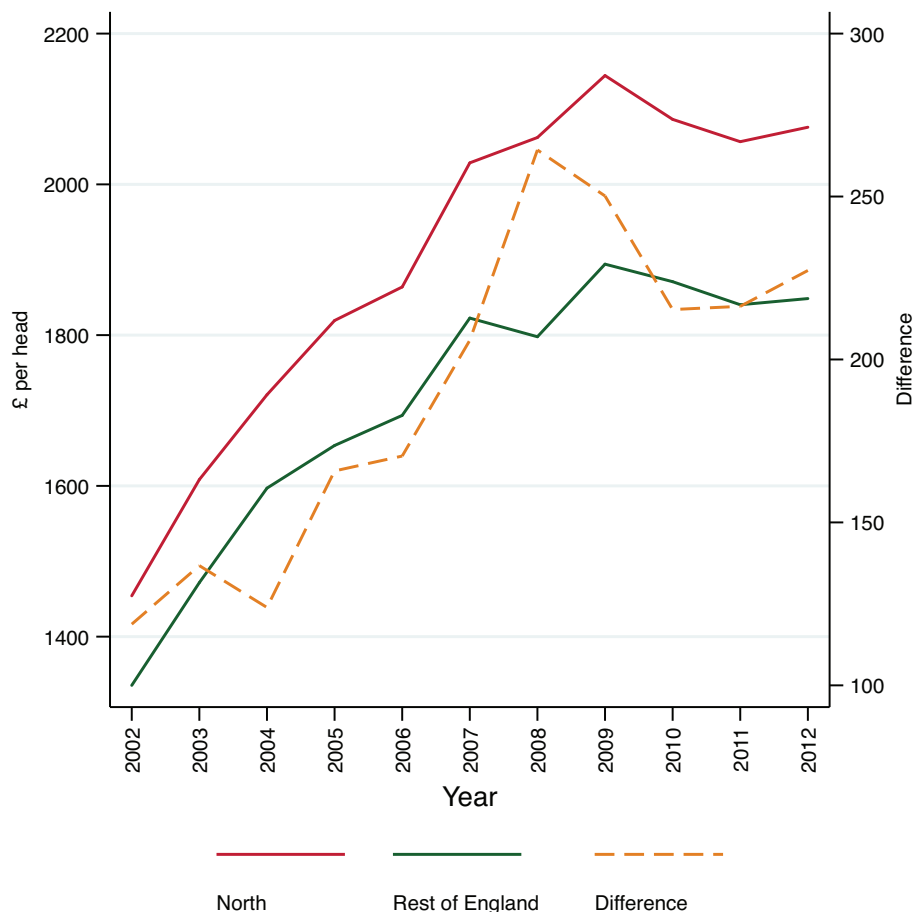
How the NHS has contributed to action on health inequalities

The NHS can influence health inequalities through three main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

One way the NHS promotes equitable health care is to allocate resources to local areas based on levels of need. The NHS has used various formulae since the 1970's to achieve this aim. Between 1999 and 2011 the UK Government added an additional objective for the allocation of resources in the NHS in England: 'to contribute to the reduction in avoidable health inequalities'.¹⁵³ As a consequence, increases in allocations during that time tended to favour more deprived areas with the North gaining a greater increase in resources than the rest of England (see Figure 27).

Figure 27: Expenditure on healthcare in the North and the rest of England

Graph shows how health care expenditure increased more in the North than in the rest of England.



Source: PESA.

Recent research in England has shown that the policy of allocating an increasing proportion of NHS resources to deprived areas led to a decline in inequalities in mortality from causes amenable to healthcare. This has contributed to a decline in the gap in mortality between the North and the rest of England.²³ However a large gap still remains indicating that there is substantial scope for health services to further reduce inequalities in amenable mortality in England. There is still evidence indicating that for some health services there is an ‘inverse care law’ whereby ‘the availability of good medical care tends to vary inversely with the need for it in the population served.’¹⁵⁴ Systematic reviews have concluded that whilst in the UK there is evidence of reasonably equitable access to primary health care by different socioeconomic groups, there is also evidence of the over-use of specialist hospital services by more affluent groups.^{155,156}

Although the NHS has clearly prevented some health inequalities, some of the principles that made this possible are now under threat. Expenditure on the NHS as a whole has increased each year since its establishment. This trend accelerated between 1999 and 2009.¹⁵⁷ Since then, as a result of the Government’s austerity policy, for the first time in its history, the amount of money available to the NHS per head of population has declined (see figure 27). This coupled with rising demand largely due to an ageing population, is putting the NHS under huge strain. It is compromising its capacity to provide a comprehensive health service free at the point of use. Changes to the way NHS resources are allocated, including the abolition of the previous ‘health inequalities’ policy, mean that cuts in funding are hitting the poorest areas hardest.¹⁵⁸

These constraints on funding have prompted some commentators to suggest that user-charges should be introduced for some core services such as seeing a GP, but to date the British Medical Association has opposed this change to funding.¹⁵⁹ There is strong

Changes to the way NHS resources are allocated, including the abolition of the previous ‘health inequalities’ policy, mean that cuts in funding are hitting the poorest areas hardest

evidence that such developments would increase health inequalities. For example, The Wanless Report presented evidence that charges can not only discourage people from seeking treatment, but can also direct people to other parts of the healthcare system that do not make charges or cause them to delay until treatment is more urgent and expensive.¹⁶⁰ There is also no evidence that changing the mix of funding for health care increases productivity or reduces overall expenditure, and it is likely that increasing the routes of funding from households to providers will limit the potential for cost containment and actually be inflationary.¹⁶¹

The Government has also introduced a major reorganisation of the NHS that has continued and accelerated a process started by the previous Government to expand the role of competition, private sector provision and markets in the delivery of health care. International evidence indicates that these policies have a negative impact on equity in health care.¹⁶² The combination of funding constraints and the expansion of market reforms are jeopardising the capacity of the NHS to take effective action on health inequalities.

Following the transfer of some public health responsibilities from the NHS to Local Authorities, the role of the NHS in reducing health inequalities has been downplayed.¹⁰ The health system has a key role in acting as a champion and facilitator to

influence other sectors to take action to reduce inequalities in health. Whilst Primary Care Trusts had a clear role in leading local partnerships to address the determinants of health in their resident populations, the evidence reviewed by the panel indicates that Clinical Commissioning Groups (CCGs) are not yet fulfilling this role to the same extent. The focus of the work of CCGs so far has been on developing the quality of health services and their primary goal has been to reduce demand for health services. Their engagement with local authorities has focused on the integration of health and social care services, rather than advocating for action on the social determinants of health. Whilst a great deal of effort is being put into managing high users of services in order to reduce demand, there is a danger that the NHS has lost its focus and influence on the social factors that are giving rise to these high levels of demand in the first place.

The NHS has yet to take full advantage of the positive impact it can have on health and local economies through its employment and procurement processes.

It is not only through the delivery of health care that the NHS has an impact on health. The NHS spends £30 billion pounds each year in the North of England and employs around 350,000 people. How these funds are spent and the working conditions of its staff, will have a major impact on health inequalities and the economy in the North of England. The NHS has been criticised for its poor track record of workplace health, and has some of the highest levels of sickness absence of any employer.¹⁶³ The Social Value Act enables public service commissioning to factor in social value when procuring services. The NHS has yet to take full advantage of the positive impact it can have on health and local economies through its

employment and procurement processes. The NHS also provides opportunities for training, however its involvement in providing apprenticeships has been limited.¹⁶⁴ There is clearly more the NHS can do as an employer and an economic force to influence the social determinants of health inequalities.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care, free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces health inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly, the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England.

As outlined above there is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes.²³ This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes. The health inequalities objective for NHS resource allocation policy has been discontinued and needs to be re-instated. To reduce inequalities the policy should be to distribute resources based on population health outcomes with an explicit objective to reduce the gap in those outcomes between the most deprived and most affluent areas.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it shouldn't be at the expense of investment earlier in the life course, which is given a high priority in all health inequalities strategies.⁹² The recent reorganisation of the NHS has had a detrimental impact on its capacity to plan health services. Roles and responsibilities are now split between multiple organisations each working on a different geographical footprint and responsible for different populations. Regional bodies for planning services over wider areas have been dismantled. Mechanisms for the local planning of health service investment need to be strengthened and more focused on effective approaches to reduce health inequalities, rather than solely focusing on short-term strategies to reduce demand. This would be helped by re-establishing the principle of having one NHS organisation, which is responsible for all of the health care for people living in an area. Action to address inequalities requires joint action across public services, this means that local NHS organisations need to plan services, integrate budgets and co-design provision in partnership with local authorities and other local agencies.

Thirdly, a more community-orientated model of primary care needs to be developed that fully integrates support across the determinants of health. Primary care is the jewel in the crown of the NHS. It is recognized as one of the strongest primary care systems in the world.¹⁶⁵ Nearly 300 million consultations take place in general practice

each year, 90% of all health-care encounters in the NHS.¹⁵⁰ Several cross-country comparative studies have demonstrated the importance of good access to primary care for improving health and reducing health inequalities.¹⁵⁰ The primary care system, however, is experiencing an unprecedented increase in workload with the RCGP and the BMA reporting that it is close to breaking point.^{166,167} A number of factors are coming together to exacerbate this. Demand across the NHS is growing, primarily because the average age of the population is increasing. But on top of this primary care is being seen as the solution to the NHS funding gap, with improved community care preventing people requiring expensive hospital care. This is shifting activity from hospitals into primary care. GPs are also reporting increases in workload as a direct result of the Government's reforms to the welfare system.⁶

The Government has responded to these issues with a plan to ensure that the top 1% of the population with complex health and care needs have a personalised care plan, a named GP and same-day telephone consultations.¹⁶⁸ Focusing on managing the conditions of the 1% of the population with the highest levels of health care utilisation will not solve these problems. The top 1% of people using primary care only account for a small proportion of the 300 million consultations in primary care each year. In addition, high health care utilisation in one year does not necessarily predict high utilisation in the following year, so such interventions frequently miss the most demanding patients. A better approach may be to enable people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.¹⁶⁹

The Marmot review⁵⁵ (and an associated report with the BMA recommended that to address health inequalities GPs should take a more holistic approach in considering the patient as a whole person within the context of his/her family, community and workplace. There has been a long history of some GP practices using primary care as a focus to integrate support across the social determinants of health together with community groups, local authorities and other organisations.¹⁷⁰⁻¹⁷² This is linked to a wider theory of community oriented primary health care long advocated by the WHO.¹⁷³ A recent report by a group of GPs working in deprived areas of Scotland, has recommended that to develop this model GPs should be supported by a new lay worker role. They would link practices with a wide range of sectors in the locality, including social services, the police, education, housing, work and employability, welfare rights and advocacy, culture and leisure, using the strong relationships with that exist with patients in general practice to develop it as a natural community hub.¹⁶⁹ Practices also need to be supported with sufficient resources to allow additional time for consultations with patients with complex needs and to support the development of long-term relationships.¹⁷⁴

Fourthly, a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area.^{175,176} However there is no national or regional strategy setting out how the Social Value Act should be interpreted by the health and

social care system making the most of economies of scale. This is something that benefits from being coordinated on a larger scale. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.¹⁷⁷

Finally, the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. The House of Commons Health Committee recently expressed concern that Public Health England was not sufficiently independent of government and that it might avoid speaking out on important public health issues that are seen as 'too controversial.'

Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Public Health England needs to be supporting and challenging all government departments to tackle health inequalities. Its expertise in Health Impact Assessment needs to be used to ensure that decisions from across government take into account their impact on health inequalities.¹⁷⁷

Whilst the new public health responsibilities of local government have the potential to strengthen joint action on the social determinants of health inequalities, effective action across central

government departments is crucial. With national targets for health inequalities no longer in place and the abolition of the cross-government public health structures in Whitehall,¹⁷⁸ the cross-government focus on health inequalities has been lost. This needs to be re-established, and Public Health England needs to be at the centre of leading a cross cross-government programme coordinating action on health inequalities.

4 RECOMMENDATIONS

This section presents the key recommendations from the Inquiry into Health Equity in the North explaining why each recommendation is needed, with more detail on possible actions under each one.

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power, and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

We did not consider that the observed health inequalities between the North and the rest of

England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, they could not account for the size and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need, must be maintained.

The Inquiry has sought to bring a fresh perspective to the issue of health inequalities that focuses on preventing inequalities occurring in the future as well as ameliorating the impact of current inequalities. Tackling the root causes of health inequalities leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations, acknowledge that most of the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

4.1 Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England

Why is this needed?

Levels of economic inequality have risen rapidly in the UK and other western countries since the 1970's. These levels of inequality have been shown to be associated with adverse health and social outcomes. This has resulted in persistent social and economic differences between the North and the South that underlie the health inequalities observed.

Economic strategy in the UK is primarily based around economic growth and creating more jobs. These economic objectives are not anchored in wider social objectives, such as reducing the large economic differences between regions in the UK, reducing inequalities or promoting health and well-being. There needs to be a shift in economic development activity to promote healthier economic policies and social inclusion. This means an approach to economic development that maximizes the social value from economic activity, promotes economic democracy, reduces inequality and provides employment that is good for health and is a route out of poverty.

Poverty, unemployment and poor housing are all markedly higher in the North. A low wage economy means that having a job does not necessarily protect against poverty in the way that it once did. The lack of growth in wages that has particularly affected the North has led to an accumulation of unsecured personal debt, which is also linked to poor health. Those on low incomes are also adversely affected by having to pay higher prices than better-off families for basic necessities like gas, electricity and banking. For those who cannot work due to unemployment,

disability or age, the value of welfare benefits in the UK is low compared to other European countries. There is good evidence linking low incomes to poor health over the course of people's lives and this has led to calls for a minimum income for healthy living (MIHL) for those on benefits. Additionally, reforms to the welfare system are adversely affecting the most vulnerable groups, particularly children and people with disabilities. To improve the health of poorer people, there is a need to ensure the welfare system provides an adequate standard of living for those who can't work. In addition, whilst there have been large improvements in the quality of social housing, families on low income are increasingly relying on poor quality private rented accommodation that is in inadequate condition, and this is especially affecting families with children.

Public services, as currently configured, have concentrated on ameliorating the impact of poverty - treating the consequences - rather than engaging in the prevention of poverty in the longer-term, which could have a major impact on health inequalities. Public service reform could help to prevent poverty and promote economic prosperity if it were focused on investing in people and places: for example, helping people to get back into work, gain better quality work and remain in work, through local integrated systems for skills and employment support; using public sector procurement to promote local high quality employment, good working conditions and training; raising living standards through action to increase wages and reduce the burden of debt; investing in affordable quality housing; and finally developing seamless universal and targeted support to families through early years education, childcare and parenting programmes.

The way public resources are allocated to local areas does not ensure sufficient resources are distributed to areas with the greatest needs or that the total public sector investment in places is used effectively to reduce health inequalities. The Government's policy of reducing public expenditure is adversely affecting populations with the worst health outcomes and falling more heavily on the North than the South. This is potentially increasing health inequalities. Additionally the current system for allocating central government funds to local areas through separate departmental silos is a barrier to joint work on health inequalities. It involves numerous complex separate formulae for different services and often comes with significant strings attached that make co-ordinated delivery, co-design and joint investment challenging. Whilst these formulae do seek to take into account differences in need as well as other factors, their objectives are often unclear and their development is not coordinated.¹⁷⁹ The level of resources allocated to local areas from across sectors should be focused on reducing inequalities in outcomes. How resources are allocated does appear to make a difference. The health inequalities objective for resource allocation in the NHS, that was in place between 2000 and 2011, for example, led to a reduction in health inequalities between LAs in disadvantaged areas and the average for England as a whole.

Agencies in the North should work together to:

- ***Draw up health equity strategies that include measures to ameliorate and prevent poverty among residents in each agency's patch.***

These measures could range from supporting networks of credit unions and other community finance initiatives to reduce the cost of credit for poor communities, controlling payday lenders, combating illegal money lending, providing debt counselling and benefits advice and working with the voluntary and community sectors to combat poverty, in addition to the following economic development recommendations.

- ***Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by reorientating services to boost the prospects of people and places.***

One key priority would be to establish integrated support across the public sector to improve the employment prospects of those out of work or entering the labour market. This should include improving transitions from school to work for young people and providing support for adults out of work particularly those with chronic illnesses and disabilities. There is potential to build a far more integrated system locally, that joins up schools, vocational training, apprenticeships, employers and employment support to ensure that young people are given the best chance to develop the skills they need to get a good job and to support out of work adults into employment. This would involve local authorities, the NHS and other agencies developing integrated support to enable people to overcome barriers to employment. For people with chronic illness and disabilities this should involve integrated case management, which combines health support with training and workplace adjustment. The extent that local agencies can achieve this will depend in part on whether funding for skills and return-to-

work programmes (e.g. the Work programme) is devolved to local areas rather than being controlled centrally (see recommendation for central government below)

– ***Adopt a common progressive procurement approach to promote health and to support people back into work.***

Through the Social Value Act Public sector bodies have the means to procure in ways which maximise the social benefit for local communities. Procurement decisions must consider how they will improve the economic, social and environmental well-being of an area. Public sector organisations within each area should, therefore, develop progressive procurement strategies to achieve the following objectives:

- Promoting high quality local employment particularly for people living in disadvantaged circumstances, including the long term unemployed;
- Improving working conditions for people in the local economy, including promoting the Living Wage; and
- Expanding training and apprenticeships to support young people into work.

– ***Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery.***

Reducing poverty and health inequalities have not been a significant consideration of Local Enterprise Partnerships (LEP) to date. With the Government increasingly emphasising the role of combined authorities and Local Enterprise Partnerships in driving economic growth, it is essential that this changes. There is a need, therefore, to ensure that all combined authorities and/or Local Enterprise Partnerships have promoting health and reducing economic and health inequalities as central objectives and that this is reflected in strategy, delivery and monitoring of performance.

– ***Implement and regulate the Living Wage at the local authority level.***

Local authorities and other local public sector organisations should implement the Living Wage and explore the potential for requiring that a Living Wage is paid for contracted and procured services. Local authorities should also work with local businesses to promote the Living Wage, for example through recognition schemes.

– ***Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.***

Many local authorities are exploring approaches to improve housing conditions in the private rented sector, including voluntary accreditation and compulsory schemes through the use selective licensing. These approaches need to be extended and evaluated. The increased reliance on poor quality private rented housing is being driven by a lack of high quality affordable housing. Public investment in new affordable homes has declined rapidly in recent years, but a number of local authorities are looking a new ways to bring in additional investment to build new affordable homes. There is scope for the creative use of local authority pension funds. For example a project in Manchester is using the Greater Manchester Pension Fund to invest in new affordable homes.

– ***Assess the impact in the North of changes in national economic and welfare policies on health inequalities in general and regional inequalities.***

Northern agencies could make a concerted effort to collect and collate the evidence on the consequences of central government policies, particularly the impact on the most disadvantaged communities in the region. This evidence can then be used to devise ways of ameliorating adverse consequences locally, as well as to lobby central government for change.

Central government needs to:

- ***Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people in work.***
- ***Extend the measuring national well-being programme to better monitor progress and influence policy on inequalities.***

The measuring national well-being programme of the ONS develops and publishes a set of National Statistics which are used to monitor national well-being across 10 domains. These include health and the main determinants of health. At present this programme just monitors average levels of well-being and does not assess socio-economic inequalities in these measures. Indicators should be developed as part of this programme to track inequalities in health and well-being across all domains. Government strategy in particular strategies related to economic development should be more closely aligned to these measures of national well-being with progress regularly assessed against these indicators.

- ***Develop a national industrial strategy that reduces inequalities between regions.***

At present the Government has invested £2 billion in an industrial strategy that is focused on supporting growth in particular sectors such as emerging technologies. Whilst this is important, there also needs to also be a clear objective to use industrial strategy to help spatially rebalance the economy and promote sustainable and quality employment that is good for health. A national industrial strategy should support decentralisation of decision-making to more effectively target resources to where they will make the greatest difference.

- ***Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular.***
- ***Expand the role of Credit Unions and take measures to end the poverty premium.***

Central government could help to create a regional infrastructure to support and greatly expand the role of local not-for-profit member owned and democratically run institutions that offer affordable credit, such as Credit Unions. The Government is currently rolling out a credit union expansion project with the Association of British Credit Unions (ABCUL) which involves £38m of funding over 3 years, to help credit unions expand and modernise. This now needs to be extended to develop a model that can realistically provide for the expansion of credit unions into disadvantaged communities on a scale that ensures they are an alternative to pay-day lenders. In addition, central government should take action to end the poverty premium, where the poorest often pay more for goods and services, such as utilities and banking.

- ***Develop policy to tackle the issue of the poor condition of the housing stock at the bottom end of the private rental market and to support local investment in affordable housing.***

Local authorities already have some powers to regulate the private rented sector where housing conditions are poor. Central government needs to work with local government to strengthen their ability to improve the quality of housing in the private rented sector. Greater flexibility needs to be given to local government to increase housing investment, including local borrowing and enabling local government to 'earn back' savings made to the housing benefit bill through investment in affordable housing.

— ***End in-work poverty by implementing and regulating a Living Wage by:***

- Legislating so that all public sector contractors and government departments pay the Living Wage.
- Providing incentives for private sector organisations to pay the Living Wage such as tapered tax breaks over a limited timeframe.

— ***Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL):***

Changes to the benefit system should take place to ensure that they provide a minimum level of income for those out of work and receiving benefits so that they can maintain health and well-being. The MIHL provides a benchmark for what is a safe minimum standard of living, which provides equality of opportunity for health and is supported by the World Health Organisation, Age UK and the Marmot Review of Health Inequalities in England. At the same time, current measures that are causing hardship, such as the 'Bedroom Tax', should be stopped.

— ***Grant city and county regions greater control over the commissioning and use of the skills budget and the Work Programme, to make them more equitable and responsive to differing local labour markets.***

Greater control over the use of the skills budget would allow city and county regions to address local skills gaps, improve school to work transitions, and develop integrated approaches that move those out of work into employment. At present, funding for adult further education (16-19+) and skills training, including apprenticeships, is mainly controlled centrally. Commissioning, accountability and planning of the Work Programme has been centrally managed by the DWP and this has not led to effective models of provision. A number of organisations and reviews have already called for some type of localisation of the Work Programme. Local partners including

Local employers, local authorities and community and voluntary organisations are best placed to set local priorities and budgets and develop integrated approaches that support transitions into employment and progression within the workplace whilst delivering what is needed to achieve local economic priorities. This would include establishing integrated support across the public sector to improve the employment prospects of those out of work, shaping further education and training provision and apprenticeships, joining up schools, vocational training apprenticeships and employment support and better integrating skills and training into the Work Programme.

— ***Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.***

There needs to be a review of current systems for the central allocation of public resources to local areas to develop a coordinated approach across government departments that is focused on the objective of reducing the gap in joint public service outcomes (including for example health, well-being, education, housing, safety etc) between the most and least deprived areas. This must take into account the differential ability for areas to raise funds through other means such as local taxation and business rates. It must also show an appreciation of poverty in rural areas across the north, which has been underestimated in the past. For example there could be a place based weighting within funding formulas which applies across the public sector, from schools, local authorities, to the NHS, where the objective is to reduce the gap in outcomes between the most affluent and most deprived areas. Just allocating resource based on need will not on its own close the gap – for this to happen resources need to be distributed so that outcomes improve at a faster rate in poorer areas. This may require even greater investment than that solely based on an assessment of need.

4.2 Recommendation 2: Promote healthy development in early childhood

Why is this needed?

Children's health is a key indicator of the success or failure of national policies. Many health outcomes for children and young people in the UK remain poor and despite important improvements more children and young people are dying in the UK than in other countries in Western and Northern Europe. Children born in the North of England are expected to live for two years less than their counterparts in the south, and experience a range of worse health outcomes. These inequalities are unfair, and have their origins in early life experiences and the environmental and social conditions in which children grow up.

To effectively reduce health inequalities we need to invest a greater proportion of public resources in the early years. However at present the opposite is happening. There are clear indications that children's services are being disproportionately hit by current austerity measures, with early years budgets facing significant cuts. A key issue is that actions need to be taken at scale, since just targeting the most disadvantaged groups is not enough.

All children have a right to the best possible health. A high level commitment to a rights based approach to improve child health will be an important driver of policies to reduce health inequalities. For example Newcastle City Council and Leeds City Council last year became only two of six local authorities in the UK to sign up to a new partnership with UNICEF, which is about committing to respect, protect and fulfil children's rights.

Agencies in the North should work together to:

- **Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need.**

- **Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs to ensure that all children achieve an acceptable level of school readiness.**

- **Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach.**

This should include reviving a model of children's centres that is based on community ownership, involving strong outreach and hubs for all services working with children, not just those provided by councils. This should include providing evidenced-based parenting programmes and services that promote children and young people's resilience.

- **Collect better data on children in the early years so that we can track changes over time, monitor inequalities in child development and evaluate services for their effects on early disadvantage.**

- **Develop and sign up to a Charter to protect the rights of children to the best possible health.**

A Charter would mean that participating local authorities would have a transformative look at the services they deliver to children and young families. It would also help in getting the message about the importance of early years embedded across different organisations. Putting child rights into public services would change practice, and in the long term deliver better outcomes for children and families.

Central government needs to:

– *Embed a rights based approach to children’s health across government.*

This would mean a high level commitment to children’s rights with the aim of improving child health and reducing health inequalities. The arguments are not just about the evidence but also that investing in children is morally and legally the right thing to do. The benefits of investing in the early years are well demonstrated, and large numbers of children stand to benefit.

– *Reduce child poverty through the measures advocated by the Child Poverty Commission*

which includes investment in action on the social determinants of all parents’ ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;

– *Reverse recent falls in the living standards of less advantaged families*

Recent economic improvements do not outweigh the damage inflicted during the downturn to the incomes of the poorest people across the country. Poorer members of society (both in and out of work) are under severe pressure. Urgent action is needed to address the cost of living faced especially by low income families, and to ensure all families can afford the ‘basics’.

– *Commit to carrying out a cumulative impact assessment of any future welfare changes*

To ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated. This would focus on the impact on people living in vulnerable situations, especially children.

– *Invest in raising the qualifications of staff working in early years childcare and education.*

The priority should be to raise the qualifications for all existing staff to level 3 and at least 30 per cent of staff trained to Level 6. The evidence clearly shows that it is essential that early years education and childcare is of high quality if children are to benefit. Extending access to childcare must therefore be supported by improvements in the quality and standards of childcare provision. The Nutbrown review commissioned by the Coalition Government has recommended that level 3 qualifications should become the baseline standard for all staff working with children.

– *Increase the proportion of overall expenditure allocated to early years, and ensure expenditure on early years development, is focused according to need.*

The Government should gradually move funding to the early years and this funding should be weighted toward the most disadvantaged children. The Government should assess and monitor the level of public expenditure on the early years by all government departments and how this funding is distributed within the country, reporting progress on shifting resources to the early years annually. The Government appointed Frank Field to conduct a review of ‘Poverty and Life Chances’. That review has recommended that resources are shifted to the early years. At present, however, it is not possible to assess the proportion of public resources from across government departments, that is being invested in the early years or to fully understand the impact on this of cuts in public expenditure.

— ***Increase investment in universal integrated neighbourhood support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.***

The Government needs to re-affirm its commitment to providing key services through children's centres. Rather than reducing their capacity, children's centres should be the community hubs providing a range of support services for parents and children under one roof, including health services. Linked to health visiting and outreach work, children's centres should reach all families.

— ***Make provision for universal, good quality early years education and childcare proportionately according to need across the country.***

Providing any education is not enough, since it is the quality of pre-school learning that appears to be critical for longer-term beneficial effects. The evidence indicates that current universal entitlement to childcare is making the most difference to children from disadvantaged backgrounds and that expanding this would increase maternal employment and improve child development.¹⁰⁶ The Government should extend universal free entitlement of early years child care and education to 15 hours a week for 48 weeks per year, for all children from the age of two until they enter school, and guarantee an additional 20 hours of subsidised childcare a week for families in which all parents are in work. This recommendation would greatly expand the current free entitlement, reflecting the evidence base that this would benefit all families, with the benefits most pronounced for those on low incomes.

4.3 Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health

Why is this needed?

The diminishing proportion of public expenditure controlled by local government and limitations on local government's capacity to raise additional resources reduces its ability to develop solutions based on local priorities. The capacity of local government to shape how public resources are used to improve outcomes for their population has been undermined by successive governments. The proportion of public expenditure in local areas controlled by local government has declined for a number of years and recent cuts to local government budgets have exacerbated this.

There are growing calls from across the political spectrum for greater devolution to city and county regions within England. There is an opportunity to influence how the process happens so that budgets and powers are decentralised and used in a way that reduces inequalities. Devolution has the potential to be a powerful force for reducing health inequalities. Giving local government more control over more public resources and enabling them to raise additional funds and use these more flexibly would help them have a greater impact on health inequalities. For devolution to have the desired impact, however, local economic development must address social objectives, be accountable to local populations and be inclusive of less connected places. Devolution has to be about more than just providing more powers for economic development and growth: it is about authorities having the ability to do what is right for the population they serve at the right spatial scale.

The most disadvantaged members of society lack influence over how public resources are used. Democratic engagement in the UK, as in many other 'wealthy' countries has declined in

recent years. The decline in political engagement is occurring at a faster rate in more disadvantaged groups. The UK has some of the lowest levels of voter turnout and some of the highest inequalities in democratic participation in Europe. The lack of influence that people from disadvantaged communities have has a number of consequences for policies to reduce health inequalities. It means that policies that could improve the health of people in these communities are less likely to be implemented and sustained and that there is less likely to be resistance to policies that exacerbate these inequalities. There is a growing body of evidence that people's health is improved when they have a greater say in the decisions that affect them and feel they can influence these. If solutions are developed locally rather than nationally, and tailored to local contexts, then they are more likely to be effective.

Agencies in the North should work together to:

— ***Establish deep collaboration between combined authorities in the North to develop a pan-Northern approach to economic development and health inequalities.***

Democratic structures such as combined authorities need to be used as a central vehicle to develop a pan Northern approach to economic development and health inequalities. There are already combined authorities in Liverpool City Region, Greater Manchester, Sheffield City Region, West Yorkshire and the North East. Together they could work to drive a programme of devolution and investment that promotes equitable economic growth, public service reform that addresses the determinants of health inequalities whilst using their combined scale to influence national policy that has an impact on health inequalities.

— ***Take the opportunity offered by the greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people in employment.***

— ***Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.***

Northern Health and Well-being Boards need to take responsibility for advocating for health equity to central government, in addition to their work with other local agencies and with neighbourhoods. Many of the determinants of local health and well-being require action at national, European or Global levels. Health and Well-being Boards in the North of England therefore could:

- Establish a Health Equity North Board with high-level political representation.

- Collectively produce an annual report detailing how regional and national policy needs to change to reduce health inequalities within the North and between the North and the rest of England.

— ***Develop community-led systems for health equity auditing and accountability.***

This requires local and national action to:

- Ensure the public reporting of actions and progress on health inequalities to encourage debate and challenges on progress by communities and other groups. Health and Well-being Boards, for example should report annually on the level of investment that has been made, actions that have been taken, and progress that has been made on reducing health inequalities.
- Make intelligence and data on health, equity and social determinants more accessible within the public domain – locally and nationally. The UK Government has led the way in developing an ‘Open Data’ policy in order promote transparency and accountability of public services.¹⁸¹ This needs to be extended with a focus on health inequalities. All public services that have a direct and indirect impact on health should collect data and report on differential access and outcomes of services by socioeconomic group. This should include services commissioned with public money from the private or voluntary sector. Data should be published to high ‘open data’ standards providing a national view down to at least the local authority level and where possible enable analysis by socioeconomic group and life course stage.

- Develop indicators of progress with local communities. Healthwatch could, for example, work with community groups and Public Health England to develop measures of progress on health inequalities at the national and local authority levels. They could involve communities in tracking progress both in terms of the community as a whole and inequalities within and between communities.

— ***Expand the involvement of citizens in shaping how local budgets are used:***

Use participatory budgeting processes to involve citizens in influencing how public resources are used so that these inform the use of a significant proportion of the total public sector investment in each area. This should involve the widespread participation of citizens in each area alongside elected representatives in the deliberation and agreement of local budgets. It should support rather than undermine the role of councilors in ensuring that public services within an area meet the needs of all citizens.

— ***Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development.***

This would involve reviewing services contracted to the private and voluntary sectors as well as those directly provided by the public sector, to assess the potential for them to be provided through public sector mutual organisations, for example tenant and employee owned social housing organisations. It will be important for systems to be in place to ensure that public sector mutuals are democratically owned and governed by services users and employees and that there is sufficient representation from all sections of the community.

— ***Help communities to develop the capacity to participate in local decision-making and in developing solutions which inform policies and investments at local and national levels:***

this should include action by local government and local NHS organisations to:

- Invest in voluntary and community sector organisations that can effectively support the greater participation of disadvantaged communities in the decisions that affect their environment.
- Invest in a process of training and action to engage community members in influencing the planning and delivery of services and to develop community assets that enhance the support available to the community.

Central government needs to:

— ***Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve.***

This could include:

- A specific aim to incrementally increase the proportion of total public expenditure controlled locally. This can help to rebalance the economy, bring national and local government closer to people, and curb inequality, but only if resources are allocated fairly and used to develop local social and economic policy that addresses health inequalities.
- Agreements between national and local government that ensure devolved funds address health equity. Any new devolution agreement or deal needs to have specific objectives to improve outcomes for disadvantaged residents - and therefore address economic and health inequalities (focusing on for example stronger communities, good quality employment, and focused help for those experiencing social and economic exclusion).

— ***Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities.***

This could include, for example:

- Granting councils greater freedom within prudential financial guidelines, to borrow to make investments that provide social and economic returns and improve health and well-being.
- Reviewing restrictions on investments by local authority pension schemes so that they can be used to make investments that promote

economic development in the North that improves health and well-being, as well as providing a return on investment.

- Exploring the possibilities of giving local authorities in England a greater share of the existing tax base to make investments that provide social and economic returns and improve health and well-being. This would strengthen local democracy, allowing local people to see more clearly what their taxes pay for locally and enable local government to shape spending priorities. This must however be done in a way that does not increase inequalities between more prosperous and less economic successful places.

— ***Invest in and expand the role of Healthwatch as an independent community led advocate that can hold government and public services to account for action and progress on health inequalities.***

Healthwatch was established to have 'a role in promoting public health, health improvements and in tackling health inequalities'. However its focus has primarily been on promoting consumer rights for users of health and social care services. We recommend that local and national Healthwatch organisations are given a clearer remit to monitor progress and advocate for action on health inequalities and to hold local and national government to account for progress.

— ***Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.***

4.4 Recommendation 4: Strengthen the role of the health sector in promoting health equity

Why is this needed

The health sector can still do much more to champion action on health inequalities and facilitating and influencing action across all sectors. Whilst action needs to be taken by a number of different agencies, the NHS and Public Health England have a specific role in leading change and advocating for health inequalities to be addressed in all policies. Following the transfer of some public health responsibilities from the NHS to local authorities, there has been a tendency to downplay the role of the NHS in reducing health inequalities. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to health inequalities. The House of Commons Health Committee recently expressed concern that Public Health England was not sufficiently independent of government and that it might avoid speaking out on important public health issues that are seen as ‘too controversial.’ It concluded that:

‘Public Health England was created by Parliament to provide a fearless and independent national voice for public health in England. It does not believe that this voice has yet been sufficiently clearly heard.’

Primary care is central to action on health inequalities, but it is under increasing strain and to remain effective needs to integrate effectively with support for the wider determinants of health and support for early child development. Increasing numbers of people are seeking help in primary care. Integrating support across agencies for the full range of problems that are driving them to seek help (e.g. employment support, debt, welfare advice, housing), will reduce pressure on GPs and

enable early intervention to prevent the exacerbation of problems, reducing poverty among people with chronic illness and reducing children’s exposure to poverty, and its consequences

The £100 billion spent every year by the NHS has huge potential to influence health inequalities, not just through the provision of services, but also through its impact on local economies. To date the NHS has not made the most of its procurement processes and employment conditions to promote high quality local employment, improve working conditions and expand training and apprenticeships.

Public Health England should:

- ***Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services, in particular focusing on the impact on children and people with disabilities.***

This should include specific work to assess the health inequalities impact of the Government's reforms to disability benefits, return-to-work programmes (i.e. the Work Programme and Help to Work) and cuts to local government budgets and should lead to recommendations on how the policies can be modified to reduce health inequalities and how changes to the tax and benefit system can ensure a minimum Income for Healthy Living (MIHL) for those in and out of work.

- ***Support local authorities to produce a Health Inequalities Risk Mitigation Strategy for the financial years 2015/16-2017/18.***
- ***Help to establish a cross-departmental system of health impact assessment.***

This should ensure that the health inequalities impact of all relevant national policies, including the Government's industrial and economic strategies, is assessed with a particular focus on spatial inequalities to ensure that they do not widen regional inequalities and the North-South divide in particular. Many government departments currently carry out Equality Impact Assessments to assist in compliance with equality duties and the current Government requires impact assessments to be carried out on regulatory policies as part of its drive to reduce the impact of regulation on businesses and individuals. The Acheson Inquiry in 1998 recommended that all relevant policies should be evaluated in terms of their impact on health inequalities; however health inequalities impact assessment is still not routinely carried out on

national government policy. Such assessments should be systematically carried out as an extension to current impact assessments processes, with a particular emphasis on the impact on regional inequalities. Public Health England should strongly advocate and influence government to ensure these policies are developed so that they can reduce health inequalities.

- ***Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise partnerships and combined authorities to ensure that reducing economic and health inequalities and promoting health and well-being are central objectives in economic development strategies.***

- ***Contribute to a review of current systems for the central allocation of public resources to local areas, including systems for the allocation of NHS resources to maximise their impact on reducing health inequalities.***

- ***Support the development of a network of Health and Well-being Boards across the North of England with a special focus on health equity***

This would include establishing a Health Equity North Board with high-level political representation providing a stronger voice enabling them to influence national policy that has an impact on health inequalities (see recommendation 3).

- ***Collaborate in the development of a Charter to protect the rights of children to the best possible health that local authorities and other organisations across the North can sign up to.***

This should affirm the duty to protect the rights of all children to the best possible health. (see recommendation 2)

- ***Work with Healthwatch and Health and Well-being Boards across the North of England to develop community led systems for health equity auditing and accountability.***

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

- ***Lead the way in using the Social Value Act to ensure that all of its procurement and commissioning maximises opportunities for high quality local employment, high quality care and reductions in economic and health inequalities.***
- ***Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained.***
- ***Work with the local authority and other agencies including the Department for Work and Pensions to develop 'Health First' type employment support programmes for people with chronic health conditions***

This would help people off-sick from work and to enable incapacity-related benefit recipients to enter or return to work. This should be based on implementing the recommendations outlined by NICE.

- ***Work more effectively with Local authority Directors of Public Health and PHE to address the risk conditions (social and commercial determinants of health) that drive health and social care system demand.***

This would mean CCGs and the local health system engaging more actively in lobbying, advocacy and public education on the prime causes of health and social care system demand. This should include ensuring that Directors of Public Health are members of their local CCG boards. This could include placing a duty to 'co-operate and collaborate' on CCGs, local authorities, and NHS Trusts.

- ***Support Health & Well Being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities, including mechanisms to support their governance, leadership, performance monitoring and democratic accountability.***

- ***Provide leadership to support health services and clinicians to reduce children's exposure to poverty and its consequences.***

CCGs and NHS agencies should take a leading role. There is a need for better data, improved monitoring, and an increased awareness of the health impacts of poverty for staff working in health services. The medical profession also has an important role in assessing the adequacy of welfare benefits for supporting health and for maintaining the principles of equity in the NHS. Furthermore, health commissioners have a key role in influencing decisions on where the cuts fall in local services, and can advocate for more equitable reforms, with the test that they must protect the most vulnerable, particularly children.

Services should develop an increased focus on a whole family approach to the care of children, with care pathways that ensure linkage to the full range of social services support available to children and families living in disadvantaged circumstances in order to mitigate some of the effects of disadvantage. This would include supporting parents to access all the benefits and services that they are entitled to, and working to reduce any perceived stigma associated with using these services. Support with the additional costs of childcare, travel to clinic appointments, and any additional medical expenditure would also help reduce the financial burden on the most disadvantaged families. This should be coupled with support to develop patient and family self-management skills for children with chronic conditions.

- ***Encourage the provision of services in primary care to reduce poverty among people with chronic illness.***

This could include for example debt and housing advice and support to access to disability-related benefits.

5 REFERENCES

- 1 Whitehead M. The concepts and principles of equity and health. *Health Promot Int* 1991; 6: 217-28.
- 2 WHO Commission on Social Determinants of Health, World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health : Commission on Social Determinants of Health final report. Geneva, Switzerland, World Health Organization, Commission on Social Determinants of Health, 2008.
- 3 Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up Part 1. Copenhagen, World Health Organization Regional Office for Europe., 2007.
- 4 UCL Institute of Health Equity. Review of Social Determinants and the Health Divide in the Who European Region. , World Health Organization, 2013.
- 5 Nutbeam D. Getting evidence into policy and practice to address health inequalities. *Health Promot Int* 2004; 19: 137-40.
- 6 Iacobucci G. GPs' workload climbs as government austerity agenda bites. *BMJ* 2014; 349: g4300-g4300.
- 7 Ed Miliband: Labour will use devolution in England to rebalance UK growth | Politics | The Guardian. <http://www.theguardian.com/politics/2014/apr/07/ed-miliband-labour-city-regions-uk-growth> (accessed 29 Jun2014).
- 8 Heseltine M. No stone unturned: in pursuit of growth - Lord Heseltine review. London, Department for Business, Innovation and Skills, 2013 <https://www.gov.uk/government/publications/no-stone-unturned-in-pursuit-of-growth> (accessed 1 Jul2014).
- 9 Lyons M, Lyons Inquiry into Local Government (Organization). Place-shaping: a shared ambition for the future of local government : executive summary. London, TSO, 2007.
- 10 David Williams. Lansley: CCG allocations should be based on age, not poverty. *Health Serv J*. <http://www.hsj.co.uk/news/finance/lansley-ccg-allocations-should-be-based-on-age-not-poverty/5044219.article> (accessed 2 May2012).
- 11 Local Government Finance Settlement 2014-15 and 2015-16. .
- 12 Department of Health. Exposition book 2011-2012 - Publications - GOV.UK. <https://www.gov.uk/government/publications/exposition-book-2011-2012> (accessed 17 Sep2013).
- 13 Beatty C, Fothergill S. Hitting the poorest places hardest. , Centre for Regional Economic and Social Research, 2013.
- 14 Bamba C. All in it together'? Health Inequalities, Austerity and the 'Great Recession'. In: Woods C, ed. *Health and Austerity*. London, Demos, 2013.
- 15 Krieger N, Rehkopf DH, Chen JT, Waterman PD, Marcelli E, Kennedy M. The Fall and Rise of US Inequities in Premature Mortality: 1960-2002. *PLoS Med* 2008; 5: e46.
- 16 Shaw C. Do social and economic reforms change socioeconomic inequalities in child mortality? A case study: New Zealand 1981-1999. *J Epidemiol Community Health* 2005; 59: 638-44.

- 17 Blakely T, Tobias M, Atkinson J. Inequalities in mortality during and after restructuring of the New Zealand economy: repeated cohort studies. *BMJ* 2008; 336: 371-5.
- 18 Cities Outlook 2014 | Centre for Cities. <http://www.centreforcities.org/research/outlook14.html> (accessed 21 Feb2014).
- 19 Hacking JM, Muller S, Buchan IE. Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. *BMJ* 2011; 342: d508-d508.
- 20 Whitehead M, Doran T. The north-south health divide. *BMJ* 2011; 342: d584-d584.
- 21 Bamba C. Reducing health inequalities: new data suggest that the English strategy was partially successful. *J Epidemiol Community Health* 2012; 66: 662-662.
- 22 Baby boys in most deprived areas show greatest increase in life expectancy - ONS. <http://www.ons.gov.uk/ons/rel/subnational-health4/life-expec-at-birth-age-65/2006-08-to-2010-12/sty-life-expectancy-gap.html> (accessed 24 Jun2014).
- 23 Barr B, Bamba C, Whitehead M. The impact of NHS resource allocation policy on health inequalities in England 2001-11: longitudinal ecological study. *BMJ* 2014; 348: g3231-g3231.
- 24 Barr B, Taylor-Robinson D, Whitehead M. Impact on health inequalities of rising prosperity in England 1998-2007, and implications for performance incentives: longitudinal ecological study. *BMJ* 2012; 345: e7831-e7831.
- 25 New Economics Foundation. Towards a Welsh industrial strategy. , 2012.
- 26 Bamba C, Barr B, Milne E. North and South: addressing the English health divide. *J Public Health* 2014; 36: 183-6.
- 27 TUC. Economic Report: the labour market in the regions of England. , TUC, 2014.
- 28 Policy Network. Mending the fractured economy -Final report of the Adonis Review. , Policy Network, 2014.
- 29 Office for National Statistics. NOMIS--official labour market statistics. 2013.<http://www.nomisweb.co.uk/> (accessed 10 Jan2013).
- 30 Erdem E, Glyn A. Job deficits in UK regions. *Oxf Bull Econ Stat* 2001; 63: 737-52.
- 31 Nickell S. The Recent Performance of the UK Labour Market. *Oxf Rev Econ Policy* 2002; 18: 202-20.
- 32 Bamba C, Garthwaite K. Welfare and Austerity. A discussion paper submitted to the Inquiry into Health Equity in the North of England. , Durham University, 2014.
- 33 Neets are 'public health time bomb'. BBC. 2013.<http://www.bbc.co.uk/news/health-24745612> (accessed 8 Jul2014).
- 34 National Housing Federation (NHF). Impact of welfare reforms on housing associations. National Housing Federation (NHF), 2014. <http://www.housing.org.uk/publications/browse/impact-of-welfare-reforms-on-housing-associations> (accessed 31 Jul 2014).
- 35 Households Below Average Income -An analysis of the income distribution 1994/95 - 2012/13 July 2014 (United Kingdom). London, Department for Work and Pensions, 2014.

- 36 The Living Wage Commission. The scale of low pay in the UK | Living Wage Commission. <http://livingwagecommission.org.uk/new-report-from-the-living-wage-commission-sets-out-the-scale-of-low-pay-in-the-uk/> (accessed 27 Jun2014).
- 37 Commission publishes response to the draft child poverty strategy - News stories - GOV.UK. <https://www.gov.uk/government/news/commission-publishes-response-to-the-draft-child-poverty-strategy> (accessed 27 Jun2014).
- 38 Taylor-Robinson D, Rougeaux E, Harrison D, Whitehead M, Barr B, Pearce A. The rise of food poverty in the UK. *BMJ* 2013; 347. doi:10.1136/bmj.f7157.
- 39 Food aid research report - Publications - GOV.UK. <https://www.gov.uk/government/publications/food-aid-research-report> (accessed 30 Jun2014).
- 40 Morris N. Demand for food banks has nothing to do with benefits squeeze, says Work minister Lord Freud. *The Independent*. <http://www.independent.co.uk/news/uk/politics/demand-for-food-banks-has-nothing-to-do-with-benefits-squeeze-says-work-minister-lord-freud-8684005.html> (accessed 30 Jun2014).
- 41 Centre for Social Justice. *Maxed Out* Serious personal debt in Britain. London, Centre for Social Justice. 2013
- 42 Lawrence, M, Cooke, G. *Jumping the Shark* Building Institutions to spread access to affordable credit. London, IPPR. 2014
- 43 Banks S, Brown G, Flaherty J, Herrington T, Waters M. *Debt on Teesside: Pathways to Financial Inclusion*. , Durham University, 2013.
- 44 Bryan, M, M T, Veliziotis, M. *Over-indebtedness in great britain: an analysis using the wealth and assets survey and household annual debtors survey*. Essex, ISER. 2010
- 45 Local authority non-decent homes: provisional estimates 2009 to 2010 - Publications - GOV.UK. <https://www.gov.uk/government/publications/local-authority-non-decent-homes-provisional-estimates-2009-to-2010> (accessed 27 Jun2014).
- 46 Kelly L. Census 2011: the facts about the housing crisis. *The Guardian*. 2012.<http://www.theguardian.com/housing-network/2012/dec/12/census-housing-at-a-glance> (accessed 30 Jun2014).
- 47 Northern Economic Futures Commission. *Northern Prosperity is National Prosperity*. , IPPR North, 2012. http://indice.astrid-online.it/La-produtt/Studi--ric/IPPR_northern-prosperity_Nov2012.pdf (accessed 31 Jul2014).
- 48 Benefit expenditure and caseload tables 2013 - Publications - GOV.UK. <https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2013> (accessed 1 Aug2014).
- 49 Bambra C, Eikemo TA. Welfare state regimes, unemployment and health: a comparative study of the relationship between unemployment and self-reported health in 23 European countries. *J Epidemiol Community Health* 2008; 63: 92-8.
- 50 Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D. Suicides associated with the 2008-10 economic recession in England: time trend analysis. *BMJ* 2012; 345: e5142-e5142.

- 51 Bambra C. *Work, Worklessness, and the Political Economy of Health*, 1 edition. Oxford ; New York, OUP Oxford, 2011.
- 52 Moser KA, Fox AJ, Jones DR. Unemployment and Mortality in the OPCS Longitudinal Study. *Orig Publ Vol 2 Issue 8415 1984*; 324: 1324-9.
- 53 Strandh M, Winefield A, Nilsson K, Hammarstrom A. Unemployment and mental health scarring during the life course. *Eur J Public Health* 2014; 24: 440-5.
- 54 Hammarstrom A. Early unemployment can contribute to adult health problems: results from a longitudinal study of school leavers. *J Epidemiol Community Health* 2002; 56: 624-30.
- 55 Marmot M. *Fair Society, Healthy Lives*. London, UCL, 2010.
- 56 Kuper H, Marmot M. Job strain, job demands, decision latitude, and risk of coronary heart disease within the Whitehall II study. *J Epidemiol Community Health* 2003; 57: 147 -153.
- 57 Marmot MG, Bosma H, Hemingway H, Brunner E, Stansfeld S. Contribution of job control and other risk factors to social variations in coronary heart disease incidence. *The Lancet* 1997; 350: 235-9.
- 58 Stansfeld SA, Head J, Marmot MG. Explaining social class differences in depression and well-being. *Soc Psychiatry Psychiatr Epidemiol* 1998; 33: 1-9.
- 59 Robone S, Jones AM, Rice N. Contractual Conditions, Working conditions, Health and Well-Being in the British Household Panel Survey. , HEDG, c/o Department of Economics, University of York, 2008.<http://ideas.repec.org/p/yor/hectdg/O8-19.html> (accessed 13 Jun2014).
- 60 Gibson M, Petticrew M, Bambra C, Sowden AJ, Wright KE, Whitehead M. Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. *Health Place* 2011; 17: 175-84.
- 61 Liddell C, Morris C. Fuel poverty and human health: A review of recent evidence. *Energy Policy* 2010; 38: 2987-97.
- 62 Richardson T, Elliott P, Roberts R. The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis. *Clin Psychol Rev* 2013; 33: 1148-62.
- 63 O'Neill B, Sorhaindo B, Xiao JJ, Garman ET. *Financially Distressed Consumers: Their Financial Practices, Financial Well-Being, and Health*. Rochester, NY, Social Science Research Network, 2013. <http://papers.ssrn.com/abstract=2255121> (accessed 1 Aug2014).
- 64 Patel V. Chronic fatigue in developing countries: population based survey of women in India. *BMJ* 2005; 330: 1190-0.
- 65 Ochsmann EB, Rueger H, Letzel S, Drexler H, Muenster E. Over-indebtedness and its association with the prevalence of back pain. *BMC Public Health* 2009; 9: 451.
- 66 Webley P, Nyhus EK. Life-cycle and dispositional routes into problem debt. *Br J Psychol* 2001; 92: 423-46.
- 67 THE CITY GROWTH COMMISSION. *Connected Cities: The link to growth.* , RSA, 2014.

- 68 The New Economics Foundation. The Good Jobs Plan. , 2011.<http://www.neweconomics.org/publications/entry/the-good-jobs-plan> (accessed 29 Jun2014).
- 69 Stiglitz JE, Sen A, Fitoussi J-P. Report by the commission on the measurement of economic performance and social progress. Paris Comm Meas Econ Perform Soc Prog 2010.<http://www.citymaking.com/wp-content/uploads/2010/01/19784660-Happiness-and-Measuring-Economic-Progress-by-Joseph-Stiglitz.pdf> (accessed 24 Feb2014).
- 70 Barr B, Clayton S, Whitehead M, et al. To what extent have relaxed eligibility requirements and increased generosity of disability benefits acted as disincentives for employment? A systematic review of evidence from countries with well-developed welfare systems. J Epidemiol Community Health 2010; 64: 1106 -1114.
- 71 Holland P, Burström B, Whitehead M, et al. How Do Macro-Level Contexts and Policies Affect the Employment Chances of Chronically Ill and Disabled People? Part I: The Impact of Recession and Deindustrialization. Int J Health Serv 2011; 41: 395-413.
- 72 Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. The public health impact of economic crises and alternative policy responses in Europe. Lancet 2009; 374: 315-23.
- 73 Health Action Partnership International and the Scottish Government. Working for Equity in Health. , HAPI, 2012.<http://www.hapi.org.uk/what-we-do/working-for-equity-in-health/> (accessed 5 Mar2012).
- 74 Clayton S, Bamba C, Gosling R, Povall S, Misso K, Whitehead M. Assembling the evidence jigsaw: insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people. BMC Public Health 2011; 11: 170.
- 75 Clayton S, Barr B, Nylen L, et al. Effectiveness of return-to-work interventions for disabled people: a systematic review of government initiatives focused on changing the behaviour of employers. Eur J Public Health 2011. doi:10.1093/eurpub/ckr101.
- 76 Warren J, Bamba C, Kasim A, Garthwaite K, Mason J, Booth M. Prospective pilot evaluation of the effectiveness and cost-utility of a 'health first' case management service for long-term Incapacity Benefit recipients. J Public Health 2014; 36: 117-25.
- 77 Nice. Management of Longterm Sickness and Incapacity from Work. , 2009.
- 78 Data shows Work Programme failures | News | theguardian.com. <http://www.theguardian.com/news/datablog/2012/nov/27/data-work-programme-failures> (accessed 24 Feb2014).
- 79 Riley T, Bivand P, Wilson T. Making the Work Programme work for ESA claimants. , Centre for Economic and Social Inclusion, 2014.
- 80 Lawton P, Cooke G, Pearce N. The Condition of Britain: Strategies for social renewal. , IPPR, 2014.<http://www.ippr.org/read/the-condition-of-britain-strategies-for-social-renewal> (accessed 1 Aug2014).
- 81 Pickett K. Addressing health inequalities through greater social equality at a local level: Implement a Living wage Policy. London: The British Academy, 2014

- 82 The Living Wage Commission. Work That Pays the Final Report of The Living Wage Commission. <http://livingwagecommission.org.uk/living-wage-commission-reveals-blueprint-for-lifting-1m-out-of-low-pay/> (accessed 30 Jun2014).
- 83 Chernev A. The Psychology of Choice Overload: Implications for Financial Services. Madison, Filene Research Institute., 2011.
- 84 Gibbons D. Improving practice in the rent to own market. , London: Centre for Responsible Credit, 2012.http://www.friendsprovidentfoundation.org/wp-content/uploads/2013/03/Church_Action_on_Poverty_-_Improving_Practice_in_the_Rent_to_Own_Market_-_Full_Report.pdf (accessed 1 Aug2014).
- 85 NAO. The Decent Homes Programme. , NAO, 2010.
- 86 NAO. Housing market renewal Housing, programme review. London, National Audit Office, 2011.
- 87 Hull A, Cooke G. Together at home. A new strategy for housing. London, IPPR. 2012
- 88 AGMA. Stronger Together Greater Manchester Strategy 2013. , 2013.
- 89 Lucas L. A third of councils are considering compulsory landlord licensing. The Guardian. 2013.<http://www.theguardian.com/housing-network/2013/may/29/councils-considering-compulsory-landlord-licensing> (accessed 30 Jun2014).
- 90 UNICEF's report on child well-being | UNICEF UK. <http://www.unicef.org.uk/UNICEFs-Work/What-we-do/Issues-we-work-on/Child-well-being/> (accessed 30 Jun2014).
- 91 Wang H, Liddell CA, Coates MM, et al. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet 2014. doi:10.1016/S0140-6736(14)60497-9.
- 92 Taylor-Robinson D, Higgerson J, Anwar E, Gee I, Barr B. A Fairer Start for Children in the North of England. , Univeristy of Liverpool, 2014.
- 93 Mackenbach JP. Can we reduce health inequalities? An analysis of the English strategy (1997–2010). J Epidemiol Community Health 2011. doi:10.1136/jech.2010.128280.
- 94 Department of Health. Tackling health inequalities: A Programme for Action. London, Health Inequalities Unit, 2003.http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268 (accessed 20 Dec2011).
- 95 Judge L. Ending child poverty by 2020: progress made and lessons learned. London, Child Poverty Action Group, 2012.
- 96 Reed H, Portes P. Understanding the parental employment scenarios necessary to meet the 2020 Child Poverty Targets. , The Social Mobility and Child Poverty (SMCP) Commission, 2014.
- 97 Brown. The Impact of Austerity Measures on Households with Children. , Institute for Fiscal Studies, 2012.
- 98 Taylor-Robinson D, Barr B. Cuts to early years children's services threaten the most disadvantaged. The Conversation. 2014. <http://theconversation.com/cuts-to-early-years-childrens-services-threaten-the-most-disadvantaged-25280> (accessed 9 Apr2014).

- 99 Allen G. Early intervention: smart investment, massive savings, the second independent report to Her Majesty's government. , The Stationery Office, 2011.
- 100 Heckman J. Skill Formation and the Economics of Investing in Disadvantaged Children. *Science* 2006; 312: 1898-900.
- 101 Bremberg S. Does an increase of low income families affect child health inequalities? A Swedish case study. *J Epidemiol Community Health* 2003; 57: 584-8.
- 102 Rajmil L, de Sanmamed M-JF, Choonara I, et al. Impact of the 2008 Economic and Financial Crisis on Child Health: A Systematic Review. *Int J Environ Res Public Health* 2014; 11: 6528-46.
- 103 Field F. The Foundation Years: preventing poor children becoming poor adults. The report of the Independent Review on Poverty and Life Chances. , HM Government, 2010.
- 104 Esping-Andersen G. Untying the Gordian Knot of Social Inheritance. *Res Soc Stratif Mobil* 2004; 21: 115-38.
- 105 Shonkoff JP, Bales SN. Science Does Not Speak for Itself: Translating Child Development Research for the Public and Its Policymakers: Translating Research for Policymakers. *Child Dev* 2011; 82: 17-32.
- 106 Ben-Galim D, Pearce N, Thompson S. NO MORE BABY STEPS A STRATEGY FOR REVOLUTIONISING CHILDCARE. London, IPPR, 2014.
- 107 Melhuish E, Belsky J, Leyland AH, Barnes J. Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. *The Lancet* 2008; 372: 1641-7.
- 108 Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention. *JAMA* 2009; 301: 2252.
- 109 Roberts H. What Works in Reducing Inequalities in Child Health? , Policy Press, 2012.
- 110 Sen A. Development as Freedom, New Ed edition. , Oxford Paperbacks, 2001.
- 111 Pickett K, Wilkinson R. The Spirit Level: Why Greater Equality Makes Societies Stronger. , Bloomsbury Publishing, 2010.
- 112 OECD. Government at a Glance 2011. , OECD Publishing, 2011.http://www.oecd-ilibrary.org/governance/government-at-a-glance-2011_gov_glance-2011-en (accessed 8 Jul2014).
- 113 Michelsen C, Boenisch P, Geys B. (De) Centralization and voter turnout: theory and evidence from German municipalities. *Public Choice* 2014; 159: 469-83.
- 114 Lodge, G, Gottfried, G. Democracy in Britain: Essays in honour of James Cornford. London, IPPR, 2014.<http://www.ippr.org/publications/democracy-in-britain-essays-in-honour-of-james-cornford> (accessed 1 Jul2014).
- 115 HM Treasury. Public expenditure statistical analyses 2013. London, The Stationery Office, 2013.
- 116 LGA. Council leaders say these cuts simply cannot go on. 2013.<http://www.theguardian.com/theobserver/2013/jun/16/letters-council-leaders-protest-cuts> (accessed 12 Sep2013).

- 117 Lodge G. Divided democracy: Political inequality in the UK and why it matters. , IPPR, 2013.
- 118 Barr B, Higgerson J. Local democracy - Enhancing community control to reduce health inequalities. , University of Liverpool, 2014.
- 119 Bosma H, Van Jaarsveld CHM, Tuinstra J, et al. Low control beliefs, classical coronary risk factors, and socio-economic differences in heart disease in older persons. *Soc Sci Med* 2005; 60: 737-45.
- 120 Syme SL. Social Determinants of Health: The Community as an Empowered Partner. *Prev Chronic Dis* 2004; 1.<http://www.ncbi.nlm.nih.gov.ezproxy.liv.ac.uk/pmc/articles/PMC544525/> (accessed 21 Feb2014).
- 121 Chandola T, Kuper H, Singh-Manoux A, Bartley M, Marmot M. The effect of control at home on CHD events in the Whitehall II study: Gender differences in psychosocial domestic pathways to social inequalities in CHD. *Soc Sci Med* 2004; 58: 1501-9.
- 122 Griffin JM, Fuhrer R, Stansfeld SA, Marmot M. The importance of low control at work and home on depression and anxiety: do these effects vary by gender and social class? *Soc Sci Med* 2002; 54: 783-98.
- 123 Bosma H. A critical reflection on the role of social democracy in reducing socioeconomic inequalities in health: A commentary on Sekine, Chandola, Martikainen, Marmot and Kagamimori. *Soc Sci Med* 2009; 69: 1426-8.
- 124 Franco A. Effect of democracy on health: ecological study. *BMJ* 2004; 329: 1421-3.
- 125 Powell-Jackson T, Basu S, Balabanova D, McKee M, Stuckler D. Democracy and growth in divided societies: A health-inequality trap? *Soc Sci Med* 2011; 73: 33-41.
- 126 Krieger N, Chen JT, Coull B, Waterman PD, Beckfield J. The Unique Impact of Abolition of Jim Crow Laws on Reducing Inequities in Infant Death Rates and Implications for Choice of Comparison Groups in Analyzing Societal Determinants of Health. *Am J Public Health* 2013; 103: 2234-44.
- 127 Mackenbach JP, McKee M. Social-Democratic Government and Health Policy in Europe: A Quantitative Analysis. *Int J Health Serv* 2013; 43: 389-413.
- 128 Kawachi I, Kennedy BP, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. *Am J Public Health* 1997; 87: 1491-8.
- 129 Hill KQ, Leighley JE. The Policy Consequences of Class Bias in State Electorates. *Am J Polit Sci* 1992; 36: 351.
- 130 Yodanis CL. Gender Inequality, Violence Against Women, and Fear A Cross-National Test of the Feminist Theory of Violence Against Women. *J Interpers Violence* 2004; 19: 655-75.
- 131 Swiss L, Fallon KM, Burgos G. Does Critical Mass Matter? Women's Political Representation and Child Health in Developing Countries. *Soc Forces* 2012; : sos169.
- 132 Young FW. Structural pluralism and life expectancy in less-developed countries: The role of women's status. *Soc Indic Res* 2001; 55: 223-40.
- 133 Ahmed S, Creanga AA, Gillespie DG, Tsui AO. Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries. *PLoS ONE* 2010; 5: e11190.

- 134 Scanlan SJ. Gender, development, and HIV/AIDS: Implications for child mortality in less industrialized countries. *Int J Comp Sociol* 2010; 51: 211-32.
- 135 Whitehead M. Is control in the living environment important for health and wellbeing, and what does this mean for public health interventions? http://phrc.lshtm.ac.uk/project_2011-2016_004.html (accessed 29 Nov2013).
- 136 Popay J, Attree P, Hornby D, et al. Community engagement to address the wider social determinants of health: A review of evidence on impact, experience & process. London, National Institute for Health and Clinical Excellence, 2007. <http://www.nice.org.uk/guidance/index.jsp?action=folder&o=34709>.
- 137 Costa-i-Font J. Does devolution lead to regional inequalities in welfare activity? *Environ Plan C Gov Policy* 2010; 28: 435-49.
- 138 Pierson P. The new politics of the welfare state. *World Polit* 1996; 48: 143-79.
- 139 Local People Demand More Power To England's Cities | Core Cities. <http://www.corecities.com/news-events/local-people-demand-more-power-englands-cities> (accessed 2 Aug2014).
- 140 GM Growth and Reform Plan : GMCA : AGMA Policy and Research Unit. <http://www.agma.gov.uk/gmca/gm-growth-reform-plan/index.html> (accessed 2 Aug2014).
- 141 Devolution for the North-east? The possibility that Scotland will govern itself has re-invigorated those in the north of England who want more local powers - UK Politics - UK - The Independent. <http://www.independent.co.uk/news/uk/politics/an-independent-northeast-the-possibility-that-scotland-will-govern-itself-has-reinvigorated-those-in-the-north-of-england-who-want-more-local-powers-9292704.html> (accessed 11 Jul2014).
- 142 Cabannes Y. Participatory budgeting: a significant contribution to participatory democracy. *Environ Urban* 2004; 16: 27-46.
- 143 Sintomer Y, Herzberg C, RöCke A. Participatory Budgeting in Europe: Potentials and Challenges: Participatory budgeting in Europe. *Int J Urban Reg Res* 2008; 32: 164-78.
- 144 Communities in the driving seat: a study of Participatory Budgeting in England Final report. .
- 145 McKenzie K. Using Participatory Budgeting to Improve Mental Capital at the Local Level. London: The British Academy, 2014
- 146 DCLG. A National Strategy for Participatory Budgeting, Giving more people a say in local spending. , DCLG, 2008.
- 147 Reed S, Usher K. Towards co-operative councils: empowering people to change their lives. , The Cooperative, 2013.
- 148 NICE. Community engagement. NICE. <http://www.nice.org.uk/> (accessed 24 Feb2014).
- 149 Davis K, Stemikis K, Squires D, Schoen C. Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. New york, The Commonwealth Fund. <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror> (accessed 9 Jul2014).

- 150 Whitehead M, Doran T, Exworthy M, Richards S, Matheson D. Delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes. Final report of Task Group 7. London, Institute of Health Equity, 2009.
- 151 Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. Quality of Primary Care in England with the Introduction of Pay for Performance. *N Engl J Med* 2007; 357: 181-90.
- 152 Mackenbach JP. An analysis of the role of health care in reducing socioeconomic inequalities in health: the case of the Netherlands. *Int J Health Serv Plan Adm Eval* 2003; 33: 523-41.
- 153 Department of Health. The NHS Plan: A Plan for Investment : a Plan for Reform. London, Stationery Office, 2000.
- 154 Tudor Hart J. THE INVERSE CARE LAW. *The Lancet* 1971; 297: 405-12.
- 155 Hanratty B, Zhang T, Whitehead M, How Close have Universal Health Systems Come to Achieving Equity in Use of Curative Services? *Int J Health Serv* 2007. 37 (1) 89-109.
- 156 Dixon A, Le Grand J, Henderson J, Murray R, Poteliakhoff E. Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization. *J Health Serv Res Policy* 2007; 12: 104-9.
- 157 Thompson G. NHS expenditure in England. London, The Library of the House of Commons, 2009.
- 158 Barr B, Taylor-Robinson D. Poor areas lose out most in new NHS budget allocation. *BMJ* 2014; 348: g160-g160.
- 159 Rimmer A. GPs vote against charging patients for their services. *BMJ* 2014; 348: g3498-g3498.
- 160 Wanless D. Securing Good Health for the Whole Population: Final Report. , H.M. Stationery Office, 2004.
- 161 Brook R, Ware J, Rogers W, Keeler E, Davies A, Sherbourne C. The Effect of Coinsurance on the Health of Adults. , RAND Corporation, 1984.
- 162 Bambra C, Garthwaite K, Hunter D. All things being equal: Does it matter for equity how you organise and pay for health care? a review of the international evidence. *Int J Health Serv* 2014; : 457-72.
- 163 Boorman S. NHS Health and Wellbeing. The Boorman review. Final Report. London, Department of Health, 2009. <http://www.nhshealthandwellbeing.org/FinalReport.html> (accessed 9 Jul2014).
- 164 FE data library: apprenticeships - Statistical data sets - GOV.UK. <https://www.gov.uk/government/statistical-data-sets/fe-data-library-apprenticeships--2> (accessed 4 Jul2014).
- 165 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; 83: 457-502.

- 166 Cooper C, Sandhu S. NHS crisis: Tory health expert warns we have 'the wrong workforce' for the future due to 'huge bias' towards training specialists - and leaving surgeries crying out for GPs. The Independent. <http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-crisis-tory-health-expert-warns-we-have-the-wrong-workforce-for-the-future-due-to-huge-bias-towards-training-specialists--and-leaving-surgeries-crying-out-for-gps-9587247.html> (accessed 9 Jul2014).
- 167 Millions facing postcode lottery over GP appointments. <http://www.rcgp.org.uk/news/2014/june/millions-facing-postcode-lottery-over-gp-appointments.aspx> (accessed 9 Jul2014).
- 168 Plans to improve primary care - Publications - GOV.UK. <https://www.gov.uk/government/publications/plans-to-improve-primary-care> (accessed 9 Jul2014).
- 169 GPs at the Deep End. What can NHS Scotland do to prevent and reduce health inequalities? Proposals from General Practitioners at the Deep End. 2013.
- 170 Greasley P, Small N. Welfare Advice in Primary Care. , University of Leeds, Nuffield Institute for Health, 2002.
- 171 Bewley H, Dorsett R, Ratto M. Evidence of the effect of Pathways to work on existing claimants. , 2008.
- 172 Popay J, Kowarzik U, Mallinson S, Mackian S, Barker J. Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part I: the GP perspective. J Epidemiol Community Health 2007; 61: 966-971.
- 173 De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M. Primary health care as a strategy for achieving equitable care. , The Health Systems Knowledge Network WHO Commission on the Social Determinants of Health, 2007. http://www.live.who.int/entity/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf (accessed 9 Jul2014).
- 174 Watt G. What can the NHS do to prevent and reduce health inequalities? Br J Gen Pract 2013; 63: 494-5.
- 175 HDA. NHS as a good corporate citizen - procurement. , HDA, 2004.
- 176 HDA. NHS as a good corporate citizen - employment. , HDA, 2004.
- 177 Buck D. Tackling health inequalities: we need a national conversation. <http://www.kingsfund.org.uk/blog/2014/02/tackling-health-inequalities-we-need-national-conversation> (accessed 20 Jun2014).
- 178 Scally G. Have we lost the battle to improve health inequalities? | The King's Fund. <http://www.kingsfund.org.uk/time-to-think-differently/blog/have-we-lost-battle-improve-health-inequalities> (accessed 7 Jul2014).
- 179 National Audit Office. Cross-government landscape review Formula funding of local public services. , The Stationery Office, 2011.
- 180 Nutbrown review reports - GOV.UK. <https://www.gov.uk/government/collections/nutbrown-review> (accessed 11 Aug2014).
- 181 Improving the transparency and accountability of government and its services - Policy - GOV.UK. <https://www.gov.uk/government/policies/improving-the-transparency-and-accountability-of-government-and-its-services> (accessed 1 Jul2014).

APPENDIX 1

Witnesses to the Inquiry

As stated at the introduction of this report, there were three focused policy sessions over the course of the Inquiry which played a key role in the development of the recommendations. Each of these sessions was attended by panel members and invited practitioners, with expertise in the relevant policy fields. The invited witnesses were.

Session one: Community and democracy

- Jo Whaley, Policy Lead, Regional Voices (Voluntary and Community Sector partnership)
- Robin Lawler, Chief Executive, Northwards Housing
- Alyson McGregor, Director, Altogether Better
- Craig Sharp, Assistant Director of Environmental Health, Preston City Council
- Paul Foley, Health Lead, UNISON North West
- Councillor Margaret Morris, Assistant Mayor, Health and Well-being, Salford City Council

Session two: Early years

- Wendy Meredith, Director of Public Health (Greater Manchester early years lead), Bolton Council
- Hazel Paterson, Service Manager, Children's Centres, Early Help Team, Liverpool City Council
- Liz Gaulton, Director of Public Health, St Helens Council
- Beatrice Merrick, Chief Executive, Early Education (membership organisation providing support for early years work and education)
- Bev Morgan, Chief Executive, Homestart Wirral
- Councillor Mark Dennet, Halton Borough Council (Chairman of Halton's Young People and Families and Policy and Performance Board)

Session three: Economic development and welfare policies

- Dr Paul Williams, GP in Stockton-on-Tees
- Charlotte Harrison, Northern Housing Consortium
- Isobel Mills (former) BIS Regional Director, Yorkshire and Humber
- Mark Jones, Head of Economic Development, Hull City Council
- Phil Witcherley, Head of Policy, York City Council
- Andrea Edwards, Stockton Food Bank

