"The NHS at 65 is facing a triple-pinch of recession, austerity and demographic change..."

HEALTH IN AUSTERITY

Edited by Claudia Wood

COLLECTION 36

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Edited by Claudia Wood

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Introduction

Claudia Wood

This paper brings together a series of short papers on the impact of austerity on health policy. It takes a holistic approach – considering the NHS and inequalities of public health, questions of structures and behaviours, and regional and historical trends. And these issues are approached by an equally mixed group of contributors – academics, politicians, practitioners. Between us, we seek to paint a broad picture of the challenges facing health policy makers through a period of economic turmoil and reduced spending. This dual challenge means one thing – fewer resources to meet increasing demand.

But how did we get here? The NHS has just has reached its 65th birthday. Until a few years ago, we might have expected our well-worn and well-loved regime of GPs, A&Es and primary care trusts to be settling down in its golden years into a period of lowest ever waiting lists, historically high satisfaction rates, and fairly decent performance on a range of measures. But the economic downturn, a new government determined to bring the deficit down as rapidly as possible, and a backdrop of demographic change accelerating from the mid-2000s has torn up the NHS's retirement plan. It has brought to the fore the uncomfortable truth that our beloved health system was becoming more and more costly, while productivity was stubbornly low. NHS spending had doubled in real terms since 1999 just to keep things on an even keel by the time the economy faltered in 2008.

Suddenly, throwing resources at our health system to keep it afloat was no longer an option, and systemic and procedural weaknesses were exposed. As Lord Darzi recently explained:

What happened in the last ten years is that the injection of cash did a lot of good. There was a huge amount of progress, fantastic outputs, fantastic outcomes. But we missed the best opportunity in the history of the NHS to actually reform it. We just threw money at it, rather than just reforming it.[1]

The new government's response to this was a radical shake up of the NHS, in the form of the Health and Care Act 2012 – bringing in a whole range of new local structures, shifting commissioning responsibilities and opportunities for a wider range of providers. As Max Wind-Cowie explains in chapter 6, this was aimed at changing the make-up of the NHS from the ground up, to make it more sustainable in a time of thrift just as in a time of plenty. But as David Hunter suggests in chapter 1, was this a solution looking for a problem? Could the same objectives, and improved financial sustainability, have been achieved through a less disruptive route?

While this debate remains a live one, and while financial pressures may seem insurmountable to those on the front line – as Branwen Jeffreys discusses in chapter 2 – these concerns actually mark a short period of difficulty in the life of the NHS. The fact remains that it is a longer term trend – that of demographic change – which will prove to be the NHS's biggest challenge. And it will be inescapable, even if our economy renders massive injections of cash once again a viable health policy.

Our society is changing around the NHS. We are living longer, and more of us are over 60. Many more are living with long term conditions and disabilities, thanks to our increasingly unhealthy lives offset by breakthroughs in medical science.

The result is that the portion of the NHS's work spent on 'treat and cure' is dwindling. Its bread and butter is now supporting people living in poor health, perhaps with multiple lifestyle-related conditions, for many years. Forget influenza – the only epidemic that will test the NHS now is obesity.

And this means only one thing. The NHS is becoming a health and behaviour management system, and the lines between it and questions of public health are becoming blurred. As Mark Britnell explains in chapter 3, the NHS can no longer start at the door of the A&E, but must get into communities – people's homes, schools and workplaces – and work in partnership with the people it is trying to help.

With this in mind, this collection considers questions of NHS and public health not simply for thoroughness, but to reflect the increased link between the two. The public health impact of economic decline – higher unemployment, job insecurity, fuel poverty, homelessness and other social ills – have a direct effect on the NHS. Moreover, the Coalition Government's response in cutting the national deficit – introducing unprecedented cuts to disability, unemployment and housing benefits, social care budgets and funding for third sector support organisations – greatly undermines our capacity to deal with these social problems.

As the assembled experts in this paper conclude, the result can only be poorer public health, increasing health inequalities, and disrupted local health structures with fewer resources to cope. Health policy makers (and indeed, local MPs and campaigners) often focus on visible change within the NHS, such as hospital closure. But they should instead be looking beyond the hospital walls – to unemployment levels, child poverty and housing costs. These now have an ever greater impact on the sustainability of the NHS as it battles conditions more closely linked to the quality of life than contagion of diseases, and are getting worse as austerity bites. And as Abrahams reflects in chapter 4, if our public health inequalities were not resolved in a time of plenty, what chance do we have now?

Three essays in this collection – by Britnell (chapter 3), Bambra (chapter 5) and Hunter (chapter 1) – provide some potential solutions, reflecting on international and historical lessons that can be learnt as many countries battle global health trends. The question is, will our health policy makers grasp this nettle? As Hunter (chapter 1) and Jeffreys (chapter 2) suggest, beyond immediate and controversial reorganisations, there does not seem to be a long term response to the

inexorable demographic change which is redefining our understanding of health and healthcare. Policy makers have yet to look beyond the hospital walls.

Note

1 Lord Darzi, in N Timmins (ed), *The Wisdom of the Crowd: 65 views of the NHS at 65*, pp 35–8, www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130704_wisdom_of_the_crowd.pdf (accessed 10 Sep 2013).

1 Safe in our hands? Austerity and the health system

David J Hunter, Durham University

Although the Coalition Government insists that the NHS budget has been protected and is not being cut, the NHS is nevertheless under considerable pressure from rising demand in part caused by cuts in public services, notably social services, as local government takes the brunt of the squeeze on public finances. There are also clinical and nursing staff shortages which underlie many of the patient safety issues identified in 14 hospital trusts by NHS England's medical director.[1] At the same time, the NHS is obliged to make savings totalling £20 billion by 2015 while simultaneously going through arguably the biggest reorganisation (or 'redisorganisation' as its critics would claim) in its 65-year history. The changes alone have been estimated to cost in the region of £3 billion.[2] It is not just the NHS that is undergoing unprecedented change but also public health, which locally has been returned to local government while nationally it is the responsibility of a new arm's length body, Public Health England (PHE).

This essay reviews the key changes introduced in April 2013 resulting from the Health and Social Care Act 2012 and occurring at a time of deep cuts in public spending. It examines the principal contradictions and tensions emerging as a direct consequence of the changes and considers their likely impact on the future direction of the health system in England.

From 'no more top down NHS reorganisation' to wholesale reform

One of the more puzzling features of the coalition government has been its determination to overhaul the NHS and public

health in the teeth of widespread opposition to the proposals for its programme of reform, which were originally unveiled in July 2010. The genesis and evolution of the changes has been documented elsewhere[3] but the majority of commentators agree that it has never been clear what the problem was to which the changes were presented as the solution. When the government took office, the NHS was performing well in the international league tables[4] and patient and public satisfaction were at an all-time high.[5] Most of what the government insisted it wanted to achieve by way of delegation to frontline staff and strengthening clinical leadership among GPs and others could just as easily have been achieved without the cost and distraction of a hugely unpopular set of changes for which there were few proponents.

Why the government should risk losing so much political capital by pressing ahead in such circumstances remains a puzzle. Unless, that is, one seeks to understand the political drivers behind the proposals. It is their ideological nature, and alignment with a government agenda committed to reducing the size of the state as an employer and public services as a major source of employment in order to create private sector jobs, which may hold the clue to comprehending the government's dogged persistence to see its changes through. As two observers put it:

The coalition programme is more than an immediate response to a large current account deficit. It involves a restructuring of welfare benefits and public services that takes the country in a new direction, rolling back the state to a level of intervention below that in the United States – something which is unprecedented… The policies include substantial privatisation and a shift of responsibility from state to individual.[6]

The public health changes: new dawn or poisoned chalice?

As mentioned above, it is not only the NHS in England which has been in a state of flux since mid-2010 but also public health. In contrast to the NHS changes, those occurring in public health, and in particular the return of the function to local government, have been broadly welcomed. There have been anxieties about the changed status of the role of directors of public health and about working in a local government culture that is alien to most of those reared in the NHS. Dealing with elected members, often for the first time, has been challenging for public health specialists; and there have been worries about transferring functions from an NHS with its protected budget to local authorities, which have been hit hard by the spending cuts of which more are predicted in the years ahead. The shift has therefore felt insecure and a leap into the unknown. But despite these very real and present concerns, there remains widespread support for local government being accorded the lead role for public health and a belief that addressing some of the wider structural determinants of health that require a whole system response might find favour in a local government setting. Many, including the director of PHE, allege that the NHS did not serve public health well in its preoccupation with hospitals, beds and acute care.

The new health system: potential contradictions and tensions

The House of Commons Health Committee, under the chairmanship of former Conservative Health Secretary Stephen Dorrell, has always maintained that the priority for the NHS is to deliver on the £20 billion savings announced by its outgoing chief executive, David Nicholson. The issue is known as the 'Nicholson challenge'. For the Health Committee, the restructuring was always a secondary issue and arguably a distraction. It is difficult to keep focused on service improvement and maintaining quality when all around the systems and structures that need to be in place are being removed, relocated or restructured.

In an unforgiving resource climate coupled with mounting pressures on the health system, the government's commitment to localism and diversity looks hollow. If history is any

guide, any attempts to let go from the centre and allow NHS England and PHE the space and freedom to chart their own destinies will be sharply curtailed as changing circumstances dictate. This is likely to become more prevalent as the next election looms. The government will be increasingly anxious to present its reforms in the best possible light to reassure a sceptical public and angry NHS staff that all the upheaval and pain has been worthwhile and is starting to show results. It is significant in this regard that leading the various stories cataloguing numerous weaknesses and failures in the NHS, and persistent health inequalities between and within areas, has been the Health Secretary, who insists that he is ultimately responsible for the NHS and what happens in it. The idea that he would distance himself from the NHS and its day-to-day management seems to have been forgotten as political expediency takes over. Perhaps it is why NHS England has expressed concern over the refreshing of the mandate which sets out the government's priorities for the NHS. There is concern that the update demonstrates 'moves into the territory of "how" the NHS should deliver rather than focusing on the more strategic question of what outcomes it should achieve'.[7] If this line is crossed, then it calls into question the whole rationale for the changes and signals that the default position of top-down control has been reasserted.

Furthermore, while the government continues to claim that its changes have simplified structures, removed management layers and stripped out costs, the reality paints a rather different picture of a vastly more complicated architecture, with many new structures and groupings being created that will need to find ways of working together. Not only does it take time for these relationships to develop but the changes are intentionally designed to create a market in the delivery of services, which risks making the goal of integrated care, now high on the policy and political agendas, much more difficult to secure. In a context where competition and choice, the two principal objectives of the reforms designed to drive up quality and efficiency, are being actively encouraged, fragmentation could be the outcome rather than improved integration and collaborative working. It is also hard to see how such a complex arrangement can save money when the transaction costs of making a market work are not insignificant. How all this is supposed to work in the interest of the public and patients is hard to fathom when a greater share of already limited resources will be sucked out of frontline services to cover the costs from lawyers' and consultants' fees. And all of this, it is worth pointing out, is occurring in a largely evidence-free zone.

Looking to the future

From where we are now, it is hard to predict what will happen as a result of the changes introduced under the Health and Social Care Act 2012. It is in any case unlikely that their impact will be immediately obvious to most members of the public. In part, this is because they have been presented as essentially managerial or technical changes that will result in improved services. But they will also become embedded over a period of years – a sort of gradual hollowing out of the NHS, which will proceed largely by stealth under the guise of its logo to give the impression that its founding principles and values remain essentially intact. But over time, the NHS will become more of a commissioning body presiding over and regulating a range of outsourced providers including Virgin Health, Capita, Serco, Care UK and others, rather than directly providing services. The third sector is unlikely to benefit much from this greater plurality.

Should this matter? The answer has to be 'yes, it does' if you are persuaded by the evidence that neither commissioning nor regulation have been noticeably successful and that governments are generally inept and lack the skills required to outsource services effectively.[8] But there is also a much wider ethical issue that Michael Sandel and others have articulated. It concerns the defence of the public interest and being clear about where as a society we might wish to set limits to markets in the belief that there are 'no go' areas, with health and education perhaps being examples.[9]

The danger is that unless we open up and engage in this debate as a matter of urgency, it will be too late. The NHS will effectively have been dismantled with a public having been softened up for such an outcome by a never-ending stream of negative, and sometimes mischievous and incorrect, stories about appalling standards of care and a media apparently failing to exercise proper scrutiny of not only *what* is happening but *why*. Compounding the problem is a woeful absence of effective opposition to the NHS changes, with the Labour party saddled with its own culpability in leading the NHS to where it now finds itself. Labour, itself in thrall to neoliberalism, still struggles to confront and break free from its recent past. It has been unable to craft a compelling alternative narrative which seeks to build on the public service ethos of the NHS.

Notes

1 B Keogh, *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview report*, London: NHS England, 2013.

2 K Walshe, 'Lansley's legacy', *British Medical Journal* 345, 2012, p e6109.

3 DJ Hunter, 'Change of government: one more big bang health care reform in England's National Health Service', *International Journal of Health Services* 41, no 1, 2011, pp 159–74; N Timmins, *Never Again: The story of the Health and Social Care Act*, London: King's Fund and Institute for Government, 2012.

4 K Davis and K Stremikis, *Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally, 2010 update*, New York: The Commonwealth Fund, 2010.

5 K Walshe, 'Reorganisation of the NHS in England', *British Medical Journal* 342, 2010, p d2038.

6 P Taylor-Gooby and G Stoker, 'The coalition programme: a new vision for Britain or politics as usual?', *Political Quarterly* 82, no 1, 2011, pp 4–15.

7 B McCarthy, *Government Consultation on the Mandate*, board paper, London: NHS England, 2013.

8 T Gash et al, *Making Public Service Markets Work,* London: Institute for Government, 2013.

9 DJ Hunter and G Williams, 'NHS "reform" in England: where is the public interest?', *British Medical Journal* 344, 2012, p e2014; DJ Hunter, *To Market! To market!*, London: Centre for Health Policy and the Public Interest, 2013; M Sandel, *What Money Can't Buy: The moral limits of markets*, London: Penguin, 2013.

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2 Mind the gap

Branwen Jeffreys

Just as modest optimism flickers about the economy, the NHS in England has been told to expect continuing austerity. It's not the first time in recent years the health service has faced such warnings. What may be greater this time round is the dissonance between public understanding and perception, and the financial realities the NHS is facing.

So who is the messenger of financial gloom? Step forward Sir David Nicholson, the outgoing chief executive of NHS England. The controversy surrounding his eight years leading the health service has been well rehearsed, but one of its defining characteristics has been balancing the books.

In July 2009, and again in July 2013, he has made his most politic interventions in the debate around the NHS by choosing to put a number on the expected gap between the funding of the NHS and the costs of running it. Those costs are accelerating with a population that has a growing proportion of people with long-term health conditions or who are simply very elderly.

The suggestion in 2009 that it would be necessary to make up to £20 billion savings by 2015 amounts to asking for a 4 per cent efficiency gain each year, something the NHS has never achieved. In the aftermath of the global financial meltdown, none of the main political parties argued with the analysis. All were completely signed up before the 2010 general election to what has become known as the 'Nicholson challenge'. Now midway through this parliament the origin of the figure under a Labour government is sometimes conveniently forgotten. The latest 'Save Our NHS' campaign video on YouTube from the Unite union simply describes '£20 billion cuts'.

The Health Select Committee and others scrutinising the attempt to deliver savings on an unprecedented scale have warned repeatedly of the danger of salami slicing. It is probable the easiest decisions that have been made first. While the big picture nationally is of a budget teetering just on the side of real terms increases, at a local level there are many hard decisions. There is about to be a step change in the level of difficulty. It will severely stress test the new structures put in place by the coalition's controversial health reforms in England.

For a public often bewildered by the monopoly money sums involved in a national health system, one lightening rod to their engagement will be changes to hospitals.

In July 2013 David Nicholson was once again briefing on the financial outlook for the NHS from now until 2020/21. NHS England is now predicting there will be an extra £30 billion funding gap, assuming the health budget remains protected in real terms and there is no gain in productivity.[1] It's worth pausing a moment on those assumptions. There is no certainty that any party will promise to protect the health budget to that extent, and at the likely expense of other areas of government spending, throughout the next parliament. It is the second assumption, around the difficulty of finding cost savings, which is central to the coming debate. No one seriously disputes the fact that the cost of providing healthcare is likely to increase at a faster rate, but the £30 billion figure may in reality be no more than a well-calibrated guess.

Perhaps because he knows he is leaving David Nicholson was particularly blunt at the publication of the financial forecast. He said that the public should not believe any political party that goes into the next election saying the financial gap could be closed without a large scale reorganisation of hospital and GP care. NHS England has set out its stall; in order to protect the universal nature of the NHS and its promise not to charge for fundamental healthcare, there would be some unpopular decisions. By early 2014, the new clinical commissioning groups are expected to have begun consulting their patients and start explaining how they might redesign NHS care in their area to cope with the future financial pressures. NHS England is promising to host larger public meetings to explore the options.

While NHS England says there are no assumptions about what the solutions might be, maintaining the current distribution of hospitals providing a wide range of services is clearly not on the menu. The debate instead returns to two long-standing strands of thinking where some hospital care is provided in fewer large centres, and longer term, less urgent care is provided wherever possible in local health centres or people's homes. In both cases it is smaller local hospitals which face the greatest changes. You don't have to close a hospital to alter its role fundamentally. It now feels as if the promise by David Cameron in 2007 of a preparing for 'bare knuckled fight' with then Prime Minister Gordon Brown over maintaining a full range of services at district general hospitals was made a long time ago.

So how might this play out in the public domain? There is good evidence that some care is better delivered by specialised teams led by senior doctors. Who wouldn't want the ambulance to drive you past local hospitals to the nearest point for urgent stroke care? There is good clinical evidence for this and some other urgent or complex hospital treatment to be reordered. The principles are hard to argue with, but translating that into deciding what should go where is a far trickier business.

There is a danger too that location of hospital care gets muddled with capacity. If routine operations and clinics stay local, and some urgent or specialist care is reorganised around the expertise of teams, how does that alter the amount of hospital beds we need in total? The Royal College of Physicians has been arguing many hospitals are working too close to capacity. The number of hospital beds has reduced markedly during the last 30 years alongside the average length of hospital stay, but the rate of change may not be consistent. There are other uncertainties too. It might well be a much better and less frustrating experience for an elderly patient with many different health needs to be cared for at home or in

a nearby surgery rather than in the local hospital. It is hard to find clear evidence of whether providing such care on a large scale would be significantly cheaper for the health service.

So the arguments for change will be constructed with some good evidence around quality. The emphasis will be on pushing decisions to a local level, although NHS England also holds significant levers via the budget for more specialised care. But make no mistake, this is also about affordability. That is explicit in the second, larger, Nicholson challenge. Instinctively local communities tend to believe it is all about money, and the NHS has been poor at making a strongly engaging case about quality. Professor Eivor Oborn described this very well in her analysis of the events in Kidderminster, where Dr Richard Taylor was elected in 2001 as an independent MP on the basis of his opposition to the closure of the A&E.[2] Essentially the local community put forward strong emotional and moral arguments in response to the colder rational arguments from the local NHS. They talked past each other, not to each other.

What has often happened is an entrenched standoff between campaigners and health service leaders. Change in the NHS, in hospitals at least, happens extremely slowly. Now acute financial pressures are pushing the health service towards making more change in the coming five or six years than in the last decade. There's little sign that will be anything other than intensely unpopular, and bringing in changes at speed may exacerbate that. In two areas, Stafford and South London, an accelerated process has been tried using a special administrator, provoking strong reactions from people in communities who feel their right to be extensively consulted has been bypassed. Special circumstances apply in each case, not least in Lewisham where the local A&E department was unexpectedly sucked into a wider review.

There is a long history of vocal protest against closure of hospital services in England. It's often inventive and highly creative. Campaigners harness the powerful narrative of personal experience and tap into the desire for the NHS to be there for us when we need it. Our unique system of tax funded universal healthcare confers a sense of ownership and entitlement. The group chorus in one campaign video for Lewisham distils this: 'All we want is access, we paid our taxes'.[3]

Throughout the last century, a local hospital providing almost all complex care has been the most potent symbol of the availability of healthcare. Now the NHS is trying to move on from that model, in the hope of finding financial efficiencies and an improvement in quality. In the absence of extra money there is that funding gap to close. The bigger gap to bridge may be between the leadership of the health service and professions, and a public that wants to exercise its right to question changes to a service paid for and used by all.

Notes

1 NHS England, 'The NHS belongs to the people: a call to action', 11 Jul 2013, www.england.nhs.uk/2013/07/11/call-to-action/ (accessed 23 Aug 2013).

2 E Oborn, 'Legitimacy of hospital reconfiguration: the controversial downsizing of Kidderminster hospital', *Journal of Health Services Research & Policy* 13, suppl 2, 2008, pp 11–18.

3 Save Lewisham Hospital A&E, Lewisham NHS Choir official song, 2013, www.youtube.com/watch?v=e3vsE8n1A-k (accessed 23 Aug 2013).

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3 International perspectives on healthcare: why we all have something to teach and something to learn

Mark Britnell, Chairman and Partner of Global Health Practice, KPMG LLP

Having experience of healthcare systems in over 50 countries, and having worked in the NHS for over 20 years and in healthcare for 24 years (four years with KPMG), I believe that we all have something to teach and something to learn. Healthcare systems around the world are experiencing an era of rapid and dramatic change as they struggle to cope with aging populations, technological advances, rising expectations and spiralling costs. To find solutions to these challenges healthcare systems must learn from the experience of healthcare providers in different countries, while focusing on leadership and patient empowerment.

Something to teach and something to learn

With this goal in mind, KPMG's Global Healthcare Practice brought 40 senior executives and clinicians, representing some of the world's largest healthcare organisations from 22 countries, together for a conference in October 2012 to share their insights, ideas and outlooks. Despite the differences between their national systems, the delegates found striking similarities in the way that payers and providers are rethinking their strategies and developing new approaches. Following the conference, we brought together some of the insights and findings in our report, *Something to Teach, Something to Learn*.[1]

Delegates attending the conference identified five major trends reshaping healthcare today:

- Payers – whether governments, public sector bodies or insurers – are becoming 'activist payers' by focusing on value, contracting more selectively, reshaping patient behaviour and moving care upstream to focus more on prevention.
- Providers need to rethink their approach as it is becoming clear that major transformational change can no longer be delayed. Some hospitals have the opportunity to transform themselves into 'health systems', providing new forms of much more extensive and integrated care and taking more risk and accountability for outcomes from payers. Others need equally radical approaches to reshape their operating models.
- There is an imperative to engage patients in new ways so that they become active partners in their care, rather than passive recipients. This requires new systems and ways of working – as one physician put it, clinicians need to change their role 'from God to guide'.
- The rise of the 'high-growth health systems', from rapidly developing countries in Asia, Africa and South America, is changing global outlooks. Unencumbered by traditional healthcare doctrines, they are innovating fast. It is a global phenomenon offering extensive learning, and opportunities for all.
- Sustainable change and better value are increasingly being seen as a direct result of new approaches to integration. A survey of our delegates revealed that 90 per cent of payers, providers and professionals believed integration would produce better patient outcomes, while three-quarters were confident that it would cut costs.

Our payer and provider participants shared some anxieties over the long-term sustainability of their respective health systems and existing care and business models, but remained confident that these challenges could be met. The conference also highlighted a central paradox, however. While nearly all of the delegates expected 'moderate or major business model change' within the next five years, there was a consensus that too many systems are still behaving as though these changes only affect other people. They are focusing on minor transactional change rather than the major transformational reform required to address future challenges.

Leadership

Making the first step along a different path requires an act of courage, and committed leadership. I believe that you need stability of leadership to promote the authenticity of relationships, which develops trust, which develops vision, which develops change. It can't happen through a process of ad hoc chopping and changing. You can't change your people and structures every three years and expect them to have a strategic vision. In *Something to Teach, Something to Learn* we call for a journey of leadership that starts with strategy and a focus on the patient's experience, patient value and outcomes.

In the past, many healthcare systems have been fuelled and driven by supply-induced demand rather than concentrating on the outcomes – what patients really need and want. Such perverse incentives cannot provoke cultural change or the implementation of best practices. Shifting the balance from volume to value will not be easy. Change requires strong leadership.

Staff make or break a mission, vision, values and purpose, yet little time is spent effectively motivating them – and holding them to account. In the best organisations that I have seen and researched, it is clear their leaders fundamentally believe 'value walks on two legs'. These leaders spend an enormous amount of effort nurturing and motivating staff. There is now a decent research base that shows motivated clinical teams produce better clinical care, which will become increasingly pertinent as globally there is a pressing need to value healthcare staff more. KPMG estimates that a workforce shortage of up to 22 per cent could exist in some developed countries by 2022.

The best organisations seem to have an inner self-confidence and discipline to pursue their mission and implement changes despite wider turbulence in local or national systems. Global examples include Virginia Mason in the US; an integrated health and social care provider in

the Netherlands called Buurtzorg; Narayana Hrudayalaya, led by Dr Devi Shetty in India; and more locally the work being undertaken in Salford. There are many more examples of innovation and good practice around the world, from which health systems, including the NHS, can learn, which we have detailed in our report.

Patient empowerment

Most systems, our own included, are heavily geared towards the five hours a year that the average citizen spends with healthcare professionals. However, I believe that the real gains are being made by health systems that understand the importance of the 8,755 hours a year when citizens are not officially classed as patients. Technological advances, such as smartphone apps which can speed a patient's hospital discharge by allowing them to measure ECGs at home, or telemedicine systems, which deliver multidisciplinary virtual clinics, offer a partial solution to empowering patients. ParkinsonNet (www.parkinsonnet.info/), a ground-breaking patient-led education programme in the Netherlands, is a great example of how this can work in practice. It has shifted perceptions about what constitutes value for Parkinson's patients and has radically changed practitioner behaviour as a result. The programme has already halved the number of hip fractures suffered by this patient group and delivered savings of £13 million.

I believe that true patient empowerment is not a bolt-on; it should be the centrepiece of the healthcare jigsaw.

Future leaders

Strong leadership will be required to shift the focus from short-term goals to long-term ambitions. The best leaders, while not shying away from the biggest challenges, will reduce complexity. They will look beyond process targets and allow space for their organisations and staff to innovate and experiment on the way to creating new models of care. The five major trends reshaping healthcare today can best be addressed by leaders who are open to looking at examples of best practice in other countries and who embrace the belief that we all have something to teach and something to learn. The healthcare leaders of the future will be those who face challenges head on, while empowering their teams and empowering patients.

Note

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4 Health inequalities: what is in store?

Debbie Abrahams MP, FFPH

Introduction

History has shown that governments set the tone for the culture of a society through their explicit policies, and what they imply. Collectively these explicit policies set out not just what governments will do and how they will spend taxpayers' money, but also what (and who) is 'worthy' (or not) of benefitting from these policies. Reflecting this, governments set out how power is to be distributed (or not). Power in this context includes income, wealth, knowledge, social status and connections.

As we now know, it is the systematic, socially produced, differential distribution of governmental resources that are the key determinants of health inequalities: increasing mortality and morbidity with declining social position. This social pattern of disease is universal and it is the social processes, influenced by written and unwritten policies, which produce it rather than biological differences. No law of nature decrees that the children born into poor families should die at twice the rate as that for children born into rich families.[1] But as governmental resources are socially produced they are also not fixed or inevitable, and this is a cause for hope.

The Coalition Government's policies and health inequalities

Unfortunately, there is little to be hopeful about as far as this Coalition Government's policies are concerned. Part 1, clause 4 of the 2012 Health and Social Care Act states that reducing health inequalities is a key objective and responsibility of the health secretary, but there is nonetheless strong

evidence that the Government's health policies will increase health inequalities, not reduce them.

The Coalition Government argued that increasing competition in the NHS is key to increasing quality and reducing health inequalities. However, recent analyses concluded that the privatisation of health services has either negative or inconclusive health equity effects[2] and does not improve healthcare quality,[3] and seven former faculty of public health presidents, 40 directors of public health and over 100 public health academics have said that the act will exacerbate not reduce health inequalities. But the Government is still pressing ahead and is not exempting the NHS from the EU–US free trade negotiations despite their promise to implement section 75 regulations.[4]

The Government's disingenuous approach to reducing the health inequalities weighting in NHS resource allocations in 2011/12 from 15 per cent to 10 per cent was breathtaking. In spite of the recommendation by the Advisory Committee on Resource Allocation that it should maintain the health inequalities weighting at 15 per cent, the health secretary at the time ignored this (after spinning a different story to the Health Select Committee). The effect was to shift resources from deprived areas with high levels of unmet health need to affluent areas with better health, for example reducing Tower Hamlets' budget allocation by 4.1 per cent and increasing Surrey's by 4.2 per cent. The Government has followed this with a campaign to base NHS resource allocation targets on a population's age profile. This would lead to the continuing haemorrhaging of funding from deprived to affluent areas, and coupled with the introduction of personal health budgets prepare the ground for these budgets to be used as health insurance premiums, which will also exacerbate health inequalities.

The debacle over standardised packaging for tobacco products and minimum unit pricing for alcohol further shows the Government's lack of conviction to tackle health inequalities in the face of powerful lobbyists.

But health policy is just the tip of the iceberg. When you look at other government policies – from education (reducing access to education by trebling tuition fees; scrapping the education maintenance allowance) to the economy (making the poorest 40 per cent worse off in the 2013 budget; backsliding on child poverty) to business (not acting on poor quality jobs and zero hour contracts; deregulation) and justice (restricting access to justice with legal aid changes), and the disgraceful misrepresentation of the facts – it is clear that the Coalition Government's ideology has nothing to do with fairness or social justice.

For example, behind the so-called welfare reforms is a 'divide and rule' attempt to vilify people receiving social security as the new undeserving poor. By using pejorative language such as 'shirkers' and 'scroungers' the Government has intentionally attempted to demonise social security recipients when in fact most (42.3 per cent) of the social security budget is spent on pensioners.[5] The Government frequently misuses statistics (as embarrassing rebukes from the Statistics Authority and the Office for Budgetary Responsibility show) in an attempt to harden the public's attitudes to the welfare state and a more equal society.

Collectively the impact of public spending cuts is significantly greater in deprived areas, and there is evidence of the relationship between public spending and, for example, life expectancy at birth.[6]

The immediate impact of these socioeconomic inequalities on health inequalities is already showing. Following the 2008–10 recession and the increase in male suicides, there were an additional 437 suicides registered in the UK in 2011, roughly mirroring the increase in unemployment.[7] It will take time before health conditions, such as cancer and heart disease, arising from this unemployment will develop, but as we know these will reflect the differential exposure to risk factors, for example relating to tobacco, and risk conditions, for example relating to unsafe work environments. They also reflect the extent of protective factors, whether people feel valued and part of society, enjoy good social relationships, and have control over their lives.[8] On the current policy trajectory the social pattern of health inequalities will continue and the gap

in life expectancy is set to increase not decrease; currently in England there is a nine-year difference in life expectancy for men and a seven-year difference for women between the poorest and wealthiest parts of the country.[9]

It does not have to be this way, as Stuckler and Basu demonstrate in their compelling book *The Body Economic* (2013),[10] which draws on Sweden's experience of recession in the 1990s and Iceland's more recent experience. The Government's indifference to addressing inequality reflects its belief in a dated theory that suggests reducing inequality decreases incentives and slows growth.[11] However, although this theory has had a number of iterations, the converse has been shown to be the case: inequality causes financial instability, undermines productivity and retards growth.[12]

Labour's record

The previous Labour Government's record on health inequalities wasn't perfect either. On the positive side, our key successes were achieving our objectives to reduce health inequalities by 10 per cent as measured by life expectancy at birth for men in 'spearhead' areas,[13] and to narrow the gap in infant mortality by at least 10 per cent between 'routine and manual' socioeconomic groups and the England average.[14] In fact infant mortality ratio data show that the relative gap in infant mortality between manual and all groups fell by 31 per cent to 12 per cent between 1997/99 and 2007/09 with a further estimated fall of 10 per cent in 2008/10 – a 25 per cent fall in relative health inequalities; the absolute gap also decreased from 0.7 per cent in 1997/99 to 0.5 per cent in 2007/09, with a further estimated fall to 0.4 per cent in 2008/10 – an overall reduction of 42 per cent.[15] This shows what can be done. But we didn't meet the headline life expectancy target for women.

As we work towards the 2015 general election there is much to learn from our previous efforts in tackling health inequalities and how we might make even greater progress in the future. There was a good start with the report *Independent Inquiry into Inequalities in Health*[16] and the Labour Government's response to this, *Reducing Health Inequalities*.[17] However, there was a hiatus in implementing action to address health inequalities until 1999 due to a commitment not to exceed the previous Conservative Government's spending plans.

Reducing Health Inequalities proposed a range of interventions to tackle the root causes of health inequalities, including the national minimum wage, introduction of tax credits, higher pensions and investment in education, housing, urban regeneration and the NHS. It included specific initiatives such as the Sure Start programme (free child care, early years education and parent support), health action zones (local action to improve health in deprived areas) and tobacco control and smoking cessation policies.

In 2001 the two national health inequalities targets were announced – to narrow the gap in life expectancy between areas and to narrow the difference in infant mortality by 10 per cent by 2010. Two years later the interventions to achieve these targets were defined in *Tackling Health Inequalities: A cross cutting review*[18] and then a year later the revised health inequalities strategy was launched in *Tackling Health Inequalities: A programme of action*.[19] It reiterated the need to focus 'upstream' at policies to address the structural determinants of health inequalities including poverty reduction and improving educational attainment, but in practice the action focused on more 'downstream' policies than in the 1999 report *Reducing Health Inequalities*,[20] for example, reducing smoking in manual groups and improving access to treatment for cancer and cardiovascular disease.

Analysing this approach there are three issues that need to be addressed in a subsequent Labour health inequalities strategy. First, there was no evidence base at the time for the health inequalities strategy to be drawn from; there was little evidence of the effectiveness of policy interventions, particularly 'upstream' policies and their differential impact.[21] For example, although damp housing causes respiratory problems, repairing or refurbishing the damp house does not reverse the health effect. In many ways the health inequalities

strategy was an action research programme on a grand scale, the largest in Western Europe. Although we now have a better understanding of the distributional health effects of many interventions, there is still more to do, particularly to look at the impacts of national policy.

The second issue relates to how policy is developed and implemented. Action on health inequalities probably requires more work across all government departments and between research and policy development than in any other area. However, recent analysis suggests that policy 'silos' and hierarchies filter new ideas and evidence, encouraging those ideas that support existing 'policy paradigms', while blocking or significantly changing more challenging positions, resulting in recycled ideas and policies.[22]

The third and most important issue is the politics of health inequalities. The selection of health inequalities targets and the interventions to achieve them seemed to reflect political timelines, understanding and commitment, including the understanding that to reduce health inequalities you need to address their root causes. Although it is noted that there was an apparent shift in views from about 2007 culminating in *Fair Society, Health Lives* (the Marmot review)[23] following the World Health Organization's report *Closing the Gap in a Generation*,[24] the commitment was inconsistent. There is other evidence, for example in *The Spirit Level*, that a more equal society and commitment to fairness and social justice benefits society as a whole.[25]

Finally

As Frank Dobson (Health Secretary, 1997–2000) said in 1998, 'Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you'll die sooner because you're badly off.'[26] Surely addressing health inequalities and their root causes must be central to a vision of One Nation?

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5 ‘All in it together’? Health inequalities, austerity and the ‘great recession’

Clare Bambra, Durham University

Introduction

This essay examines the effects of economic downturns on inequalities in health – how sudden economic change can exacerbate the large health differences that exist between social groups in all developed countries, such as the infamous 28-year gap in male life expectancy between the most and least affluent parts of Glasgow.[1] Using international research evidence, I argue that inequalities in health between social groups have increased during past downturns in some countries but not in others. The essay reflects on how this is related to different international social security systems, some of which are better than others at protecting vulnerable groups in times of hardship. It will then reflect on the potentially negative health impacts of austerity and conclude by arguing that the current ‘Great Recession’ – in which the economic downturn is accompanied by the pursuit of austerity in the UK – will only serve to divide our nation’s health further. We are not ‘all in it together’.

Economic downturns and health inequalities

In many ways it is still too early to be conclusive about the effects of the current ‘Great Recession’ on health inequalities. We therefore have to look back on data from past economic downturns to gain insights in to what to expect this time around.

There were post-war economic downturns in the 1970s, 1980s and 1990s in the UK and other Western countries.

The epidemiological literature suggests that while the general health effects of these events were rather mixed.[2] The majority of international studies concluded that all-cause mortality deaths from cardiovascular disease and motor vehicle accidents and hazardous health behaviours *decrease* during economic downturns, while deaths from suicides, rates of mental ill health and chronic illnesses *increase* in some – but not all – countries.[3] The effects on socio-economic inequalities in health also appear to vary substantially by country context.[4]

For example, a study of the Japanese working age population found that economic downturn increased inequalities in self-rated health among men,[5] while a Finnish study found that the economic downturn slowed down the trend towards increased inequalities in mortality.[6] Similarly, a comparative study of working age (16–64) morbidity conducted in Finland,[7] Norway,[8] Sweden[9] and Denmark[10] found that inequalities in self-reported health remained stable during the 1980s and 1990s.[11] Another comparative study also found that self-rated health inequalities increased much more in England than in Sweden during recession and that the health of the Swedish population also recovered more quickly once the recession ended.[12] These findings are supported by a study of inequalities in preterm births in the social democratic countries that remained broadly stable from 1981 to 2000 despite economic downturns.[13]

The literature therefore suggests that health inequalities in more social democratic countries are not as strongly influenced by economic downturns and the associated changes in income and labour market inequalities. This may be because the comparatively strong social safety nets they provide buffer against the structural pressures towards widening health inequalities.[14] The welfare states of the social democratic countries – in contrast to others – seem to protect the health of the most vulnerable during economic downturns.

Austerity and health inequalities

In economics, 'austerity' refers to reducing budget deficits in economic downturns by decreasing public expenditure and/or increasing taxes. In the UK, since 2010, this has been characterised by the former with large scale cuts to central and local government budgets, NHS privatisation (see Hunter, chapter 1) and associated cuts in welfare services and benefits (see Wood's introduction to this collection). The most comparable existing studies on which to draw are those of the effects of past welfare state expansion and contraction on health inequalities. These suggest that while overall health is unaffected, inequalities in mortality and morbidity increase when welfare services are cut.

For example, a US study found that while premature mortality (deaths under age 75) and infant mortality rates (deaths before age 1) declined overall in all income quintiles from 1960 to 2002, inequalities by income and ethnicity decreased only between 1966 and 1980, and then increased between 1980 and 2002.[15] The reductions in inequalities (1966–80) occurred during a period of welfare expansion in the USA (the 'War on Poverty') and the enactment of civil rights legislation, which increased access to welfare state services. The increases in health inequalities occurred during the Reagan–Bush period of 'austerity' when public welfare services (including health care insurance coverage) were cut, funding of social assistance was reduced, the minimum wage was frozen and the tax base was shifted from the rich to the poor, leading to increased income polarisation.

These findings are mirrored in studies of welfare state restrictions in New Zealand,[16] which found that while general mortality rates declined, inequalities among men, women and children in all-cause mortality increased in the 1980s and the 1990s then stabilised in the early 2000s. The increases occurred during a period in which New Zealand underwent major structural reform (including a less redistributive tax system, a targeted social benefits, regressive tax on consumption introduced, privatisation of major utilities and public housing, user charges for welfare services, and a more deregulated labour market). The stabilisation of inequalities in mortality in the late 1990s and early 2000s was during a period in which the economy improved and

there were some improvements in services (eg better access to social housing, more generous social assistance and a decrease in health care costs).

Research into the health effects of Thatcherism (1979–90) has also concluded that neoliberalism, the large scale dismantling of the UK's social democratic institutions and the early pursuit of 'austerity-style' policies increased health inequalities. Thatcherism deregulated the labour and financial markets, privatised utilities and state enterprises, restricted social housing, curtailed trade union rights, marketised the public sector, significantly cut the social wage via welfare state retrenchment, accepted mass unemployment and implemented large tax cuts for the business sector and the most affluent (Scott-Samuel et al, in press). In this period, while life expectancy increased and mortality rates decreased for all social groups, the increases were greater and more rapid among the highest social groups so that inequalities increased.[17] These rises were not inevitable as in the UK – like the USA and New Zealand – inequalities in mortality declined from the 1920s to the 1970s as income inequalities were reduced and the welfare state was expanded.[18]

Health inequalities in the 'great recession'

The current economic downturn is popularly referred to as the 'Great Recession' as it has been longer, wider and deeper than any previous economic downturns including the 'Great Depression' of the 1930s. Bringing the existing research literature together suggests three things about the likely effects of the 'Great Recession' on health inequalities in the UK:

- the importance of social safety nets in mitigating health inequalities during economic downturns: insights from the research reviewed above suggest that austerity may exacerbate health inequalities in countries like the UK because they have inadequate social safety nets
- that austerity is likely to increase inequalities: following Stuckler and Basu[19] it is not economic downturns *per se* that matter but the austerity and welfare 'reform' that may follow: that 'austerity kills' and – as I argue here – that it particularly 'kills' those in lower socio-economic positions
- that the UK's pursuit of austerity during the 'Great Recession' could be a double whammy: the UK government has chosen to pursue a policy of austerity during a time of unprecedented economic downturn; it seems very likely that our nation's health will be divided further

Therefore, despite political claims to the contrary, we are not 'all in it together' as the health effects of the 'Great Recession' will be felt more by some in our society than others.

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6 Health and innovation in a time of austerity

Max Wind-Cowie, Demos

You would have to be breathtakingly stupid or remarkably glib to claim that a recession has no impact on health. Of course it does. As Professor Bambra and others have shown – the relationships between poor health and unemployment, debt and financial insecurity is well established and incontrovertible. Add in budgetary pressures and of course there is the potential for a sicker population less well served by the NHS.

But less money does not have to amount to a worse service. And austerity can be an opportunity as well as a challenge. It is difficult for politicians to admit to this proposition – no matter how much they may believe it in private – because the oppositional nature of contemporary politics means that any nuance is elided in a rush to condemnation. So let me say this for them: tighter budgets may, in the long term, be a good thing for the NHS.

In times of almost unrestricted funding, the NHS could get away with grotesque inefficiency, expensive bureaucracy and wilful blindness about the costs of treatment. Spending ever increasing amounts of money to buy improving outcomes is attractive in the short term. But over time it is unsustainable – and would be whether or not we had entered a time of restricted spending and state retrenchment.

The growth in 'lifestyle' illnesses such as obesity-related heart disease and type-2 diabetes, coupled with increased longevity and expensive developments in treatment for a wide range of illnesses, mean that the NHS was always going to have to confront difficult decisions about costs at some point. The cost in the UK of providing optimum cancer treatment alone, for example, is predicted to rise by 62 per cent over the next decade while the

proportion of NHS clinical spend on treating diabetes (currently around 10 per cent) is set to rise to 17 per cent.[1]

Austerity – and the ring-fencing, but not inflating of, the NHS budget – is therefore merely a taster of the potential constraints under which future clinicians and NHS managers might find themselves. That is why it is so important, and positive, that the Coalition Government has used the necessities of austerity to innovate and reform the structures of the NHS – to improve efficiency and management and keep costs under control over the long term. Rather than salami-slicing the budget of the NHS budget, lopping bits off here and there, the Coalition has focused on real and substantive reform. It deserves praise for undertaking this difficult process.

Driving down costs

It is almost a taboo in British politics to discuss the price of health care. Raised with the doctrine of clinical help being free at the point of use, most of us find talking about how much treating the sick costs vulgar and troubling. But money matters – in health as in other public services – and it is irresponsible in the extreme to pretend that the high cost of clinical care in the UK is irrelevant. When money is wasted in one place – on inefficient treatment, on spiralling costs – it affects the availability of other services elsewhere in the system. We all have an interest in pushing down the price of healthcare wherever possible.

This Government's reforms to the commissioning structures of the NHS hold out hope for bearing down on costs without the punitive impact of systems that place responsibility for paying solely on the patient. There has been no 'privatisation' of the NHS. Rather, GPs – acting in consortia – are being explicitly asked to include the price-tag attached by providers in their list of considerations when referring a patient. Consortia who take this responsibility seriously will be rewarded.

This creates an incentive for GPs to take seriously the wider impact of the clinical decisions they make on behalf of their patients. That is not to say that other factors – what the *best* treatment for a person may be – cease to count, or even to take precedence. But it is to say that once a course of action is decided upon, family doctors should factor in how much different providers charge when deciding where an individual ought to be treated.

In turn, this creates an incentive for hospitals and other healthcare providers to ensure that – as well as performing to a high standard – they operate in the most efficient way possible. A provider that fails to take seriously the necessity of keeping costs to a minimum will fall out of favour with commissioners.

This reform is about a duty of care to the communal resource that is our NHS. It is not about 'making a profit' but about being socially responsible and considering the systemic context in which individual clinical decisions are made.

Proactive public health

It is something of a cliché that the NHS is, in fact, a 'national sickness service'. But despite its hackneyed use, there is much truth in that critique. We have not been particularly good at driving up general standards of public health in the UK – in particular, we have been singularly bad at understanding and tackling the extreme health inequalities that stem from wildly divergent standards of public health related to differing levels of socio-economic status. This has to change if, over the longer term, we are to keep the costs and impact of lifestyle illnesses under control. Individuals and families will *have* to take more responsibility for protecting themselves against avoidable sickness if we are to maintain an NHS that operates cradle to grave and free at the point of use – which is what almost everyone in politics wants.

The devolution of public health services represents a huge opportunity to engage more proactively, dynamically and successfully in preventing sickness. That is not to say that there aren't also challenges. By focusing resource at the local level, and giving power to local health and wellbeing boards, we can recognise the differing challenges facing different communities

and make public health spending targeted and accountable. But there is a good way to carry forward these reforms and there is a bad way. Good local health and wellbeing boards will be innovative and imaginative when choosing which agencies they invite to become involved.

Of course GPs consortia and primary care providers should work with elected officials on these new boards – but so too should local housing providers, social care agencies, schools and even employers. The essays in this collection bring home how cross-cutting and interdependent public health is with other areas of public policy. We need to recognise this in the composition of local health and wellbeing boards so that we can use them to improve cross-agency working and to align public health work with the needs and resources of specific communities.

This relates back to the question of how we can drive down the price of healthcare while protecting service. In the case of commissioning treatment, the answer has been to create the incentive to care about cost. In the case of public health, we need to ensure that cross-cutting approaches are being built into our systemic approach so that inefficiencies and duplicated costs are eliminated over time.

Conclusion

Of course no government would want to be forced into the corner that this Government has found itself in. And naturally, there are risks attached to implementing spending cuts and freezes in healthcare. But the Coalition deserves praise and recognition for dedicating itself to a path of reform and innovation to preserve and improve the NHS in the long term – rather than simply cutting or downsizing its scope and service offer. Creating in-built pressure to drive down costs and devolving responsibility for public health – so that local challenges can be met and silos overcome – are examples of a dynamic approach to reducing spending and improving outcomes. That approach is vital to meeting the short-term problems caused by recession and retrenchment but, more importantly, will also be central to future-proofing it against rising costs, greater longevity and booming lifestyle illnesses.

Note

1 Bupa, 'New approaches to diagnosing and treating cancer urgently needed to avoid a £5.9billion shortfall', 2011, www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bupa-updates-archive/cost-of-cancer-report (accessed 16 Sep 2013); NHS Choices, 'Diabetes: cases and costs predicted to rise', 24 Apr 2012, www.nhs.uk/news/2012/04april/Pages/nhs-diabetes-costs-cases-rising.aspx (accessed 16 Sep 2013).

7 Conclusion: divided kingdom? Health, the regions and austerity economics

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the breeding places of disease, the infamous holes and cellars in which the capitalist mode of production confines our workers night after night, are not abolished, they are merely shifted elsewhere. The same economic necessity that produced them in the first place, produces them in the next place.

Engels, 1935 [1872]

Introduction

There undoubtedly are important relationships between the health of the economy and the health of the population, although these are not always intuitively obvious. For example, as Engels noted, private profitability may depend on people working long hours in unhealthy environments and/or performing physically dangerous tasks, often working beyond legally permissible limits, in a succession of places. While this remains the case in many parts of the world,[1] in the contemporary UK the relationships between human health and economic performance are generally expressed rather differently, although illegal and pollutant workplaces that are damaging to health have not completely disappeared there. Other contributors to this volume have noted that there are important regional variations in the relationship between health and the economy which may be exacerbated in a period of austerity. In this essay, I will consider the social and geographical relationships between the economy and health, in particular between and within regional differences in economic performance and

population health and wellbeing in the UK from the nineteenth century to the present period of austerity.[2]

The nineteenth and early twentieth centuries: the regional question – from the inevitability of regional inequality to the emergence of regional policies

The onset of industrial capitalism dramatically redrew the map of regional differences in economic performance and for more than a century this was simply regarded as a natural and inevitable characteristic of capitalist development. The UK, or more precisely those parts of it that were the birthplaces of industrial capitalism (such as Liverpool, Manchester and Newcastle), became the first 'Workshop of the World' and the centre of a global empire. Part of the price of this economic success for a few was that many people lived and worked in dangerous and polluted environments that seriously damaged their health, often leading to premature death. This became increasingly well documented by pioneering social researchers[3] and early studies found, for example, that in the nineteenth century the life expectancy of labourers in Liverpool was much lower than that of labourers in Bath. From the late 1920s, however, there was a growing realisation that such stark regional inequalities in economic wellbeing and population health and living conditions were neither inevitable nor unavoidable. Moreover, they might trigger social discontent and political unrest. This helped bring about a significant change in central government thinking, accepting that such inequalities could, to a degree, be ameliorated by government action. From the 1930s, this led to the emergence of regional policies, intended to keep inequalities within politically and socially acceptable limits. This reformist tendency was significantly strengthened following the election of a Labour government in 1945, which brought in many new policies that strengthened regional policy and, crucially in this context, created the National Health Service (1948). This offered the potential to address problems of disparities of regional economic performance alongside those in health and wellbeing.

The immediate post-war years: changing patterns of regional economic inequality and population health and wellbeing

Until the early 1960s, regional differences in unemployment rates narrowed under the stimulus of post-war recovery programmes, but as global economic competition intensified, regional inequalities re-emerged more sharply. Narrowing disparities in regional economic growth rates was seen as the key to stimulating faster and non-inflationary national economic growth by enhancing growth in the lagging regions and by dampening down growth in the South East and West Midlands. This was an initiative of Conservative governments in the late 1950s and early 1960s, but was intensified following the election of the Wilson-led Labour government in 1964. However, concerns about the links between economic inequalities and regional differences in health and wellbeing were, and remained, at best muted as the creation of the NHS was seen (erroneously, as it happened) to be addressing such problems.

1970s to 1990s: emerging recognition of regional differences in health, wellbeing and health care

The National Health Service was partly intended to reduce social and regional inequalities in access to health care and in health outcomes, but from the 1970s onwards it became very clear that this was far from the case and that health care access and health outcomes were not equal across social groups or between communities. The critical moment was the Black report into inequalities in health of 1980.[4] It revealed marked class inequalities in illness and death rates. Despite the creation of the NHS, class differentials in ill-health and premature death were shown to have widened. One aspect of this was that the more educated and affluent middle classes were better able to access health care and ensure that the NHS met their needs. Another factor was the class-based exposure to damaging physical and social environments – including, as previously noted, the nature of work There were also clear links between health, wellbeing and place.

These geographies of inequality were exacerbated by the marked inequalities between and within regions in the allocation of resources within the NHS.[5] A much more generous per caput provision of resources in the south east resulted in a clear north–south divide in health care provision and in health and wellbeing, which mirrored the differences in economic performance and wellbeing. While regional differences in health expenditure were somewhat narrowed in the 1980s, regional differences in economic performance and unemployment increased, more than counteracting the effects of narrowing differentials in public expenditure on health care. Expanding regional differences in economic success – with the south east economy heavily underpinned by public expenditure while such expenditure was cut in the northern and peripheral regions in the 1980s – was associated with an increasingly differentiated regional geography of wellbeing, with poor health disproportionately concentrated in those regions suffering from deindustrialisation and economic decline.

The relationships between geographies of economic success and population health and wellbeing were more subtle than simply this broad, regional north—south divide, however. In the affluent south east, there were significant pockets of poor health in inner London, often associated with immigrant populations and areas of industrial decline,[6] as well as declining seaside resort towns and former naval dockyards. Equally, in the north there were pockets of relatively good health in affluent places such as parts of Cheshire and rural market towns across the region converted into affluent commuter settlements. However, alongside these in the north there were much greater swathes of poor health and premature mortality in deindustrialised towns and cities and in former mono-industrial places, most notably former coal-mining settlements, devastated as a result of Thatcherite and subsequent New Labour and Coalition Government economic policies.[7] In such places, the legacies of occupationally specific illnesses and diseases – such as pneumoconiosis ('black lung' disease), or certain cancers – and the general legacy of hard physical work in demanding and often dangerous workplace environments combined with the effects of chronic worklessness on the mental health of those who had lost their jobs in the 'old' industries and those denied the opportunity of finding work because of deeply depressed local labour markets.[8] In such places, the cumulative effects of poverty and multiple deprivation – coded in New Labour speak as 'social exclusion' – wreaked havoc on the health and wellbeing of people and place.

Global financial crisis and the regional politics of UK austerity

The UK economy was particularly vulnerable to the effects of the financial crisis that exploded in 2007/08 and subsequently spread to infect the 'real economy'. This was because from the 1980s a succession of national governments of all political persuasions had pursued economic policies that prioritised the banking and financial services sectors (City of London) to the detriment of the rest of the economy and the rest of the national territory. This was a very class and place-biased policy choice. Barely more than a decade after jettisoning Clause 4 of its constitution, the New Labour government de facto nationalised significant swathes of the banking sector, a clear expression of the depth of the crisis and of the class priorities of a capitalist state when push did come to shove. The subsequent response manifested in successive waves of public expenditure cuts fell particularly heavily on places like the North East, which perversely had become more dependent on public expenditure and public sector employment because of the previous closure and privatisation of formerly nationalised industries.

Despite the rhetoric of 'rebalancing the economy' in truth there was little capacity to do so – private sector manufacturing was now no more that 10 per cent of the national economy, so claims about restoring non-inflationary national growth by evening out regional economic imbalances (the deeply ironic parallels with the 1950s went virtually unremarked) and

stimulating a private-sector manufacturing export-led recovery were less than convincing.[9] As a result, spatial inequalities in economic performance and labour market conditions grew further and despite the commitment by the Conservative–Liberal Democrat coalition to protect NHS expenditure nationally, so too did inter-and intra-regional differences in health and wellbeing. And this looks likely to be the case for the foreseeable future as the national economy, at best, stages a weak, unbalanced and halting recovery, which still leaves output well below pre-crisis levels. It is predicted that the age of austerity will continue for at least another five years and quite conceivably longer than that.

Conclusions

The prognosis for the future is not a happy one then, for many people and places. An ageing population with increasing health problems poses a great societal challenge, not least in the provision of social care. Many will be forced to work longer before becoming eligible for a state pension, with little option other than seeking to find paid employment for longer. Already over one million people aged 65 or more are employed in the labour market. One consequence of this growth in the number of post-65 employees will be further competition for any jobs that are created. While there is great emphasis in government statements on the numbers of new private sector jobs that have been created, much less is said about the fact that a majority of these are part-time, temporary and poorly paid so that some people have to hold more than one job at once just to 'get by'. For those in relatively physically undemanding white collar occupations working longer for a wage may be feasible, but for those in unskilled manual work the prospect may be less attractive, or not even possible. Given the geography of the labour market, there will be also be a geography to who can and cannot work longer as well as a geography of who lives longer and in good health and who lives in areas where quality of life is poorer and life expectancy shorter. In an increasingly Divided Kingdom (as Prince Charles referred to it in 1985), we most definitely will not be all in it together.

Notes

1 R Hudson, 'Thinking through the relationships between legal and illegal activities and economies: spaces, flows and pathways, *Journal of Economic Geography*, 2013, pp 1–21

2 R Hudson and A Williams, *Divided Britain*, 2nd ed, Chichester: Wiley, 1995; R Hudson and A Williams, *Divided Britain*, reprint of 1st ed, Paris, Mallard Editions, 2000

3 For example F Bell, *At the Works*, London: Virago, 1985 [1907].

4 P Townsend and N Davidson (eds), *Inequalities in Health: The Black report*, Harmondsworth: Penguin, 1982.

5 Ibid.

6 For example, see N Buck et al, *Working Capital: Life and labour in contemporary London*, London: Routledge, 2002

7 K Bennett et al, *Coalfields Regeneration: Dealing with the consequences of industrial decline,* Bristol: Policy Press, 2000

8 For example, see O Jones, *Chavs: The demonization of the working class*, London: Verso, 2012.

9 R Hudson, 'The changing geographies of manufacturing and work: made in the UK?' in NM Coe and A Jones (eds), *The Economic Geography of the UK*, London: Sage, 2010

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The NHS recently reached its 65th birthday, but it is not settling down into its golden years with ease. Instead, it is faced with a triple-pinch of an economic downturn, fiscal tightening and ongoing demographic change. These conditions have brought to the fore the uncomfortable truth that our health system is becoming more and more costly, with productivity stubbornly low. The Coalition Government's response to this was a radical shake up of the structures of the NHS, in the hope that this would make it more sustainable in a time of thrift, but the success of such a policy is far from certain.

This collection brings together a series of papers on the impact of austerity on health policy. It takes a holistic approach – considering the NHS and inequalities of public health, questions of structures and behaviours, and regional and historical trends. These topics are approached by an equally mixed group of contributors – academics, politicians, practitioners – who paint a broad picture of the challenges facing health policy makers through a period of economic turmoil and reduced spending.

The collection presents compelling evidence of the public health impact of economic decline – higher unemployment, job insecurity, fuel poverty, homelessness and other social ills – that has a direct effect on the NHS. It also emphasises that, though current budget restrictions may be tough for the frontline, it is the longer-term trend of an ageing population which will prove to be the NHS's biggest challenge. However, the question that remains is whether health policy makers will grasp this nettle, and make the necessary response to demographic change which is redefining our understanding of health and healthcare.

Claudia Wood is Deputy Director of Demos.

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