Health, equity and the north of England: a case study on a new approach†

Paul Johnstone*

Public Health England, North of England Region, Blenheim House, West One, Leeds LS1 4PL, UK

*Correspondence address. E-mail: paul.johnstone@phe.gov.uk

†The views expressed in this paper are those of the author.

Accepted 23 September 2015

Abstract

Introduction or background: In 2013, responsibility for public health returned to local government from the National Health Service (NHS) in England. This article describes, as a case study, a new fresh approach to tackling health inequalities, which built on a desire by local councils in the north of England to rethink approaches and collaborate on new ideas to improving health and reducing health inequalities.

Sources of data: The collaboration was supported by an independently commissioned inquiry that assessed the evidence and proposed new policy options. This article describes the context to the collaboration, called Health Equity North, findings from the independent inquiry and emerging impact. Four areas for action were recommended: linking poverty with economic prosperity, devolution and public sector reform, investment in early years and renewed impetus for the health sector.

Areas of agreement: That health service action alone had been limited without addressing the wider determinants of health such as employment, education and housing.

Areas of controversy: The so-called north-south divide appears to be widening, and renewed efforts are needed locally and nationally to tackle these wider determinants of health.

Growing points: This collaborative approach spanning a large geography supported by local and national leaderships, enabled new work locally and influenced policy nationally, such as devolution of power and resources to local areas.

British Medical Bulletin, 2015, 116:29–41
doi: 10.1093/bmbldv048
Advance Access Publication Date: 17 November 2015

© The Author 2015. Published by Oxford University Press. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com
Areas timely for developing research: Research is needed on the economic returns of investing in the social determinants of health. The examples of local action indicate the need for research on ‘asset-based approaches’ to improving community health, presented so to empower local lay decision makers such as councillor rather than for technical experts.

Key words: health inequalities, social determinants, new approaches

Introduction
On April 1, 2013, the Health and Social Care Act (2012) came into force. Amongst many controversial changes to the NHS (in England) included the transfer of responsibility for public health from the NHS to local government. This was a significant re-alignment for the local public health function, from largely a technical role in commissioning health services to being part of a local democratic body to improve population well-being for a place. A full history of public health can be found elsewhere, but of relevance here is that for the first time since 1974 this reorganization heralded an opportunity for public health practitioners to directly focus on the deep-seated causes of ill health and inequality, such as poverty, housing and the environment and protecting children’s well-being—which where the public health movement started in the nineteenth century. In the last 40 years, against a background of stubborn or worsening health inequalities, there have been increasing calls to tackle these wider social determinants of health. In 2004, the first national plan for inequalities, ‘Tackling Health Inequalities—A Programme for Action’ was launched and required local areas to meet targets to reduce health inequalities. Yet locally actions by the health service and on lifestyle changes were still prioritized. In 2010, the government-commissioned Marmot Review was published, which clearly set out the evidence and actions needed to tackle the wider social determinants of health, thus setting the focus for future roles for public health.

The recession from 2008 and the impact on health and inequalities provided further context for focused action on wider determinants. It was clear that this recession was having a differential impact on deprived areas and the north of England in particular saw the return of headlines on the so-called widening ‘north–south divide’. This, coinciding with interest in England on opportunities for devolution following the Scottish independence referendum, sets the context and formed a catalyst for a collaboration across the north of England with councils, the voluntary sector, academics and practitioners to look at fresh ideas and approaches to tackling health inequalities.

Impact of recession, health and devolution
The recession

The recession in 2008 and subsequent austerity appear to have had a differential impact across England. In the early 2000s, employment rates were similar in the north to that of London. Then following 2008, the biggest reduction in employment was seen in the north (defined as the three government regions of North East, North West and Yorkshire and the Humber). Since 2010–11, employment rates for men and women have risen in all regions but more rapidly in London, suggesting that the recovery has been the slowest in the north, further increasing inequality between the north and the south (see Fig. 1). A similar trend is seen across a number of other economic indicators, such as mortgage repossessions (Fig. 2).

The coalition government from 2010 introduced policies to reduce the public sector deficit and ‘rebalance’ the economy and encourage private sector growth. The Office of Budgetary Responsibility predicted that 3.1 million private sector jobs would be...
created between 2010–11 and 2018–19, which would more than balance the expected 1.1 million reduction in public sector jobs over the same period. Yet the Institute for Fiscal Studies showed that northern areas, which depended more on public sector jobs, were the slowest for private sector growth. More recently, the Centre for Cities reported in 2015 that between 2004 and 2013, for every 12 net additional jobs created in cities in the south, one was created in cities elsewhere in Britain.

Over this time, there were changes to local government funding, which appear to have had a differential impact. Figure 3 shows changes in council spending power from 2010 to 2016 with the largest cuts appearing to affect northern councils. Figure 4 shows the reduced spending power per household, which, along with London, show the north regions being affected most.

The Centre for Cities also published internal migration trends based on Office of National Statistics data. Between 2009 and 2012, they suggest that net flow of economically active people from the north to London has increased, in part due to differences in job opportunities across the UK, especially for higher skilled jobs. These trends appear to have an added effect and contributed to the widening economic inequality between the north and south particularly London.

**Health outcomes and media interest**

The impact of recession and austerity on health and inequalities has been well documented. Of relevance here is that accessibility of health inequalities information generated wider interest from councils, local leaders and the media. This was evident with one of the first releases of Public Health England’s (PHE) ‘Longer Lives’ website on premature mortality (Fig. 5). The example in Figure 5 shows health inequalities as a traffic light map, in this case on the differences in council population-based life expectancy.

This more accessible information generated much interest locally with councils, local agencies and the media—which led to a return of headlines on widening ‘north–south divide’.

**Call for devolution in England**

The Scottish independence referendum in 2014 reawakened a similar debate for England. Previous experiments with regional devolution included Regional Assemblies, Government Offices for the Regions and Regional Development Agencies, which were abolished in 2010. For local economic development, ‘local enterprise partnerships’ (LEPs) have been established, led by business leaders and tasked to develop local economic plans including for transport, housing and infrastructure.

In addition, some councils have joined forces with neighbouring councils to form ‘Combined Authorities’, which aim to increase power influence for regeneration on bigger geographies and are also referred to as ‘City Regions’.

By 2014, all main political parties had expressed their desire to support devolving powers with calls for a ‘northern powerhouse’ and investment in infrastructure similar to that of London. However, LEPs and
national economic ambitions state that their aim is to improve Gross Domestic Product and create jobs, with usually no linked aim to reduce poverty, improving health and well-being in the most deprived areas, which would reduce inequality.

A new collaboration: the approach taken and why

In this context and the new role of public health, councils and partners from across the north of England met in Blackpool in February 2014 and agreed to collaborate, to raise the profile and to seek fresh approaches and actions to health inequalities nationally and locally. It was agreed to call this movement Health Equity North and to use the ‘fairness commissions’ approach adopted by some councils locally, but at a broader scale. To support it, an independent inquiry was commissioned, chaired by Professor Margaret Whitehead at Liverpool University together with senior officials from local government, respected academics, directors of public health and local practitioners. The inquiry was supported by the Centre for Local Economic Strategies (CLES) based in Manchester. Its remit was to focus on the root causes of health inequalities and on the contributions that national and
local governments, NHS, the voluntary sector and other agencies can make.

Due North Findings

Fig. 5. The opening page on the PHE Healthier Lives web-based map, showing premature mortality across every local authority in England, which led to calls to reduce the so-called ‘north–south divide’ (www.healthierlives.phe.org.uk).

The inquiry panel met three times in the spring of 2014 and invited national and local witnesses to give evidence. The panel’s report, Due North, was published in September 2014. It made 68 recommendations and grouped these into four broad themes:

- economic development and living conditions,
- early childhood as a critical period,
- devolution (including community empowerment),
- the role of health services in tackling inequality.

For each theme, two areas for action were identified: (i) actions locally and (ii) actions for national agencies and government. What follows is a short discussion for each theme.

Economic development and living conditions

The Inquiry found that regional differences in economic development—weaker labour markets, more worklessness, poverty and lower living standards in the north compared with the south—have contributed to a greater burden of ill health in the north of England. Economic conditions, employment and material living standards are fundamental determinants of health. The effects of poverty and economic disadvantage were found to be more pronounced in the north as since around 2004, poor neighbourhoods in the north have had worsening health than places with similar levels of poverty in the rest of England (Fig. 6).

Based on this assessment, the Inquiry recommended linking planning and investment in economic prosperity to public service and services on preventing poverty, and implementing the ‘Living Wage’ for all jobs. It recommended improving affordability and quality of housing and stressed the need to assess the impact of national and local economic and welfare policies on health inequalities, drawing on the WHO initiative ‘Health in All Policies’. Also nationally, it recommended an industrial strategy to reduce inequalities between regions, expansion of credit unions, ensuring that welfare systems provide a minimum income for healthy living, ending employment poverty through the Living Wage, developing housing policy to tackle poor condition of housing stock at bottom end of private rental market, and granting city and country regions more control for resources.
Early childhood as a critical period: promoting healthy development in early childhood

The Inquiry sets out a context of relative disadvantage for children growing up in the north of England, where there are higher levels of child poverty (which has increased nationally), and underlines the established evidence base for early intervention. Children born in the north of England are expected to live 2 years less than their counterparts in the south and experience a range of worse health outcomes. These inequalities originate from early life experiences and the environment and social conditions in which children grow up. Due North demonstrates that rather than prioritizing investment in early years, the opposite is happening where child health services are being hit by austerity measures.

The Inquiry proposes increasing the provision of good-quality universal education and childcare support through children’s centres. It advocates a ‘rights-based’ approach to promoting child health and measures proposed by the Social Mobility and Child Poverty Commission to enable parents to care for their children, such as paid parental leave and flexible working. It also encourages local authorities to sign up to the United Nations Children’s Fund (UNICEF)-developed rights charter that commits statutory organizations to respect, protect and fulfil children’s rights. Finally, it calls for more accessible information on child health particularly on the cumulative assessment of welfare changes to help mitigate the negative effects of these.

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

The Inquiry argues that those who have less influence are less able to affect the use of public resources to improve their health and well-being. Where people feel they can influence and control their living environment, there are likely to be health and well-being benefits.

The move to devolve greater powers and resources to cities and local government will enable locally
focussed economic growth and reduce regional inequalities, and local growth strategies should include objectives to promote health, well-being and reduce health inequalities. This needs to be accompanied by devolution to communities with public participation in local decision-making.

Yet, democratic engagement in the UK, as in many wealthy countries, has declined, and this is the fastest in the most disadvantaged groups as demonstrated by poor voter turnout. Indeed, *Due North* identified poorer voter turnout in the north of England. The consequences are that policies that could improve the health of these communities are less likely to be implemented and sustained, and conversely there is less likely to be resistance to policies that exacerbate inequalities. They recommend deepening the collaboration across northern agencies to support new approaches to economic development and health inequalities, and use devolved powers and resources to develop locally integrated programmes to support people into employment. To support this, more accessible data are needed on social determinants, which encourage citizen involvement in shaping services. Investment in Healthwatch to hold government and services to local account should be further strengthened.

**Strengthening the role of the health sector in promoting health equity**

The Inquiry proposes a range of actions for the NHS and PHE to influence health inequalities, beyond the provision of equitable high-quality healthcare; through its procurement of goods and services, its role as an employer using the Public Services (Social Value) Act, and as a champion and facilitator that influences other sectors to take action. The move of Directors of Public Health and teams to local government has further exacerbated a tendency for the NHS to downplay its role in well-being and inequalities. The Inquiry asks that the NHS and PHE locally and nationally need to speak up fearlessly on inequalities. Primary care needs to be integrated with other agencies such as employment support, debt, welfare advice and housing, with a focus on supporting disabled people and children. This will reduce pressure on General Practitioners (particularly for those in deprived areas managing large multiple morbidity caseloads), enable early prevention and reduce poverty and children’s exposure to poverty. Across government, they recommend a cross-departmental system of health and inequalities impact assessments and, through this, challenge central government departments to tackle health inequalities.

**Discussion: impact and opportunities for local and national agencies**

*Due North* generated widespread interest on health inequalities nationally and locally. It stimulated debate in local government, the voluntary and community sector, academia, NHS and local media. Nationally, PHE has published an initial response, and a further response has been published. The report’s recommendations looked to consolidate, strengthen and align work already in progress in many areas. The following discussion refers to these examples and where better alignment and scale will add value, with a brief critique of the recommendations for each of the four *Due North* themes.

**Reducing health inequalities through growth and employment**

The inquiry’s fundamental call is that economic growth plans should also aim to reduce poverty and improve health. But planning should not be top down. Many previous regeneration schemes had limited impact when imposed from outside. Rather, economic planning should be built on the assets that already exist in communities, and the government’s role, locally and nationally, is to work with and nurture these assets.

LEPs are essential to this. In Leeds, for example, the City Region’s Strategic Economic Plan was developed in partnership with the Joseph Rowntree Foundation, aiming to promote growth and poverty reduction as a single ‘connected agenda’, through increasing average pay levels indicated by the Living Wage. Furthermore, the housing sector has an important role. It has an estimated workforce of 250 000 in the UK and often works in the most deprived neighbourhoods. They have a wealth of local insight and
opportunities to engage with communities to enable ‘health improvement from within’. For example, the Adactus Housing Group manages 13 000 properties across the north. Through a partnership with Unify Credit Union based in Wigan, they offer low-cost loans as an alternative to high-interest alternatives. Adactus also supports tenants who have been out of work for a long time, with counselling and assistance with IT, CV writing and interview skills.

The Public Services (Social Value) Act requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of local areas. Blackburn with Darwen Council have used the Act to employ local people and organizations to commission its services rather than from outside the district. At scale, this Act provides a significant level to increase local employment and reduce inequalities. Another relevant example of improving health of employees is the ‘North East Better Health at Work Award Scheme’, coordinated by the Trades Union Congress and covering over 160 000 employees—21% of the workforce. Evaluations are showing productivity gains as well as health gains.

Promoting healthy development in early years

The evidence is clear that interventions to promote a healthy start in life are fundament to reducing health inequalities in a generation. Yet agencies in the north and nationally appear unable to provide these interventions at scale in the current policy and fiscal climate, and levels of child poverty according to the Commission for Social Mobility and Child Poverty have increased. Locally, this requires imaginative partnerships well beyond local areas, but there are examples of where this is happening. Two councils, Newcastle and Leeds (out of six nationally), have signed new partnerships with UNICEF, which commit them to ‘respect, protect and fulfil children’s rights in their policies and services’.

Greater Manchester has developed an ‘early years delivery model’, which aims to bring about a population-level shift in school readiness, including an eight-point process for better data and monitoring, training, re-orientating to evidence-based services and interventions, and evaluation. This has been identified for prioritization in the Greater Manchester Devolution Agreement (discussed below).33

Prioritizing interventions and services for early years remains a mixed picture. There is an urgent need to reduce the variation and decline in outcomes in children in different areas of the country. This can be helped through adopting ‘health in all policies’ with a focus on children’s health, both nationally (across all government departments) and locally in councils and NHS services. Developing children’s rights approach at every level will encourage this.

Share power and resources and increase the influence that the public has on how resources are used to improve the determinants of health

Due North argues that the proportion of public expenditure controlled by local bodies, and their ability to raise additional resource and develop solutions to local priorities has been diminished for many years, and that recent cuts have exacerbated this. The UK government has called for a north of England ‘powerhouse’ and more power to City and County Regions. In 2014, the 10 councils that make up Greater Manchester, with the British Government Treasury, announced its intention to work together with Whitehall on devolution. In 2015 with NHS England, Greater Manchester Councils also signed a Memorandum of Understanding to support devolution of NHS resources to the City Region (although national control for the NHS). In July 2015, PHE, NHS England and Greater Manchester signed a third memorandum on public health services. These memoranda explicitly link the purpose of devolution to improving health and social outcomes and reducing inequalities.

But devolution to cities and region alone will not create the conditions for community engagement as envisaged in Due North. To make decisions at the right spatial scale, it is essential that work is undertaken with local communities, engaging and building on local assets. The Voluntary, Community and Social Enterprise (VCSE) sector, who often work with
the poorest and the most marginalized communities, has a particularly important role here. Locally, it is a service provider, employer, a source of intelligence, campaigner and partner. Changes in attitude and approaches, particularly from the statutory sector, are required, which would better support the contribution of VCSE organizations in response.39

**Strengthening the role of the health sector in promoting health equity**

The move of the public health function to local government has risked the NHS downplaying its role in tackling inequalities and influencing the social determinants of health particularly in primary care, despite this being a statutory requirement for Clinical Commissioning Groups. Locally, there is variation in the understanding of their public health role and addressing the inverse care law, which was first described by Dr Julian Tudor-Hart over 40 years ago.40 However, the recent NHS plan, ‘Five Year Forward View’, heralds a sea change in attitude, recognizing the critical NHS role in reducing inequalities and improving population health, whilst acknowledging that the rising burden of avoidable illness is ‘influenced by, and in turn reinforce[s], deep health inequalities which can cascade down the generations’.41

Nationally a new Diabetes Prevention Programme board has been established and new NHS planning guidance published asking for closer working of clinical commissioning groups with local authorities on the wider determinants of health, and sharing of the best practice on commissioning to reduce health inequalities (http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf).

Locally, initiatives such as Well North are providing a vehicle for NHS and local engagement. This collaborative pilot programme, supported by PHE, with councils and Manchester University, will develop, test and pilot a set of linked interventions working with communities to improve health and well-being in the most deprived areas of the north of England.42

Nationally evidence-based guidance on community-centred approaches for health and well-being has been published by PHE, and the NHS has launched a ‘NHS citizen initiative’. But there remains a need for significant development for the health sector where there is confusion and lack of resources or expertise. As discussed earlier, the Social Value Act requires all agencies to invest in their local areas to promote local employment and development (as assets). But the NHS and particularly the provider sector rarely engage with this approach. There are opportunities for deeper and more connected commissioning, pooling budgets not just between councils and the NHS but with neighbourhood budgets, housing and the VCSE. Health and Wellbeing Boards must be enabled to provide the infrastructure for this, and these budgets should be devolved to communities. Finally, PHE itself needs to develop its role still further as an advocate, and there are plans to use its unique role both nationally and locally to work with other government departments to develop a ‘Health in All Policies’ approach.

**Overall approach of the health equity north collaboration and research implications**

This case study shows that, as an initiative, Health Equity North has contributed to raising the profile of health inequalities and provides fresh ideas and policy options for the whole country as well as the north of England. The commissioning of an independent inquiry provided further credibility and impetus. Although most of its recommendations are not new, with the move of public health responsibility to local government, the audience has changed and Due North has helped to reframe the narrative.

There are other differences to previous attempts to tackle health inequalities. Firstly, there is unprecedented interest in devolution, and Due North’s findings have played straight into that debate locally, as seen in Greater Manchester. As a result, the aim to improve health and reduce inequalities is cited as key to reason for devolution. Secondly, with continuing pressure to reduce public debt, there is more public debate about the impact of austerity on health and the NHS in particular. Finally, the initiative has helped to shape future work for national agencies, particularly PHE and NHS England. There is the potential for a coherent approach to health inequalities for both
upstream and downstream determinants. *Due North* has contributed to the wider work on inequalities in other local areas across England. There are lessons here for other countries too, in creating opportunities for framing actions within a local democratic context rather than a technical commissioning environment.

There are a number of risks to the effectiveness of the approach—which may impact negatively on the collaboration. First the political will, nationally and locally, to embrace policies on devolution and inequalities may be short lived or be limited. However, the evidence that devolution should continue to communities is compelling. Amatya Sen, Nobel Prize winner and economist, said that the fundamental cause of inequalities in health is the relative lack of control and powerlessness of less privileged groups. The same was concluded by Marmot. The real test for devolution will be to engage communities and transfer power to them—starting with the most deprived areas. Secondly, the future direction and speed to recover public sector debt will be influential. *Due North* makes a clear link to poverty and policies on austerity, but uncertainty remains on the direction of travel of the new UK Government in 2015. Finally, there are decisions to be made about the degree of engagement with Whitehall departments to systematically check their policies for impact on health, well-being and health inequalities. This is where national agencies can step up and influence, with impartial and focussed evidence. Without further tangible outcomes, the collaboration of Health Equity North becomes at most a sharing best local practice initiative.

**Conclusion**

The public health function returned to local government in England in 2013 at a time when the country was recovering from recession and austerity. The impact of this and the upturn appears to have had a differential impact on the north of England with media and local concern of a widening ‘north–south divide’. This article describes, as a case study, a collaboration called *Health Equity North*, of councils across the north of England, with the voluntary sector, NHS and academia to seek fresh ideas and policy options to improve health and reduce inequalities focussing primarily on the wider determinants of health. Previous attempts to tackle health inequalities focussed on lifestyle behaviour modification and treatment services, but this supported an opportunity to take a public health approach to tackling social determinants of health.

Commissioning an independent inquiry strengthened the collaboration, and its report, *Due North*, helped to focus fresh action on four areas of recommendations: to bring together economic growth plans to reduce poverty, on interventions for early years, on devolution of power and resources and enhancing the role of health sectors. This article discusses these recommendations, how they have aligned to local democratic context, requiring community led action such technical public health approach has limitation to enable change. Rather, we should be assessing ‘assets’ as well as needs, and this should be accessible to the general public. Coloured maps are of limited use in deprived areas, which are often blanketed traffic light red. Trend data for smaller areas than council populations are likely to be of more value in local discussions and community-based decision-making. So too would locally available data on employment and the Living Wage, which should be routinely used as a well-being measure. Similarly, rather than measuring levels of disability, an assessment of ‘enablers’ would be helpful, i.e. what has changed to enable people to live more fulfilling and empowered lives as an outcome. This asset-based approach to research will be particularly helpful in developing primary care in deprived areas.

**Research implications**

There are relatively few examples of economic impact on investment in the social determinants of health to support investment decisions, and there is a call for more research. Such ‘return on investment’ evidence will help decision makers make the connection to improved economic outcomes for deprived areas and reduced demand for services.

Routinely measuring well-being and inequalities needs further research and development. The traditional approach is to measure ‘needs’ and to commission services to meet those needs. But in a local
action with examples and strengths and limitations of approaches. Health Equity North provided the catalyst, recognizing that the environment to enable actions rests within local democratic organizations as opposed to commissioning ones. This is a challenging and long-term agenda, with messages globally, nationally and locally—but the one that cannot be neglected.

Acknowledgements

I would like to acknowledge my colleagues Tracey Sharp, Diane Bell, Alison Patey and Caroline Machray for comments and advice on the article, Jake Abbas and Simon Orange for technical information. More widely I thank Mel Sirotkin as chair of the steering group for Health Equity North and other PHE colleagues Steering Group members including Stephen Morton, Jane Rossini, Martyn Regan, Roberta Marshall and members of the Health Equity North. I thank Professor Margaret Whitehead and her team and Due North panel for their huge contribution to the debate and Neil McInroy at the Centre for Economic Studies. Nationally I would like to acknowledge Kevin Fenton, Jonathan Marron, Ann-Marie Connolly and Ann-Marie Hamilton for their support.

Conflict of interest statement

The authors have no potential conflicts of interest.

References


40. NHS Clinical Commissioners Survey of Clinical Commissioning Group on Their Public Health Role and Local Advice Service from Local Councils. 2015. (Unpublished).


