



Crumbling foundations

**The impact of failing public services
on health and productivity**

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Summary

Poor health is doing profound harm to the wellbeing and productivity of the UK's population, and social determinants of health are to blame. Educational disadvantage is the most significant social determinant of life expectancy while unemployment and income are leading determinants of health. These factors, along with others such as exposure to crime, are driving alarming disparities between the number of years people in England can expect to live in different places. To reverse these trends, improving outcomes across these social drivers of health must be a priority.

This paper makes the economic case for investment in public services to improve population health, productivity and fiscal sustainability. It will be followed by a paper setting out national policy proposals for reform.

The link between social determinants and locally designed and delivered public services is crucial: a healthy, productive society cannot be built on crumbling public services and hollowed out local infrastructure. Spending must be reformed to enable investment in preventative public services, determined and delivered by local leaders, to achieve the transformation in educational outcomes, employment and earnings that is needed.

Bold action today has the potential to reduce simultaneously the pressure on future services and generate productivity and economic growth for the benefit of people and communities.

Findings from new CPP analysis on the health impacts of socio-economic inequality:

- New analysis by CPP finds that on average, 1.5 years of life per person in England are being lost due to inequalities in income, unemployment, poor quality housing, exposure to crime and access to employment and education. This is equivalent to 81 million life years lost across England.
- The impact on health is even greater, with people in England losing an average of 2.6 years of healthy life due to socioeconomic inequalities, equivalent to 144 million total lost years of good health.
- Educational disadvantage is the most significant social determinant of life expectancy. The factors affecting health are harder to account for, but CPP's model suggests that unemployment and income are the leading determinants. Policies aiming to improve long-term health and longevity should look towards education, training, income and unemployment support.

Reaching crisis point:

- The UK is the only developed country where the proportion of working-age people not employed or seeking work has continued to rise since the height of the pandemic. This is partly being driven by increasing numbers reporting multiple health conditions.
- This increase in multi morbidity accentuates a longer-term trend which is partially responsible for higher A&E admissions and pressure on acute and emergency services.
- Staff shortages in social care and community nursing trusts are also exacerbating pressures on emergency departments by forcing the withdrawal of services which could prevent admissions, and preventing discharge from hospitals.

A new approach to resourcing places is needed:

- Public finances are on an unsustainable path due in part to healthcare costs, so the solution cannot just be to spend more on the NHS. CPP analysis of OECD countries shows that countries that have increased spending on social protection and education have experienced improvements in life expectancy, while lower spending growth within countries was associated with slower improvements in longevity and infant mortality.
- NHS spending on obesity is forecast to rise to £9.7 billion per year by 2050 and malnutrition is currently estimated to cost £19.6 billion per year. Conversely, community mental health services are associated with lower costs of care. Spending on early intervention and prevention must be seen as an investment in people that can boost long term productivity and fiscal sustainability.
- Greater Manchester has demonstrated the potential benefits of coordinated local service delivery – including action on the social determinants of health - with life expectancy growing more than expected since devolution in 2014.
- Recognising this emerging evidence base and the good work local institutions have already done to start to shift towards population health and prevention, the government must facilitate the maturity of existing convening organisations like Integrated Care Systems and their integration with Mayoral Combined Authorities (MCAs), and other public service delivery structures to shift the trend on health and productivity.

Introduction

Both health and productivity have been flatlining in the UK for over a decade, with output per hour worked 34% lower in 2020 than implied by pre-crisis trends.¹ The dip and bounce back in output caused by the pandemic has now settled back at 2019 levels, while life expectancy has fallen.

A healthier and more productive society cannot be built on public services that are crumbling into disrepair and ambitions to deliver sustainable, inclusive economic growth are reliant on building public services that can meet the needs of every community. In doing so they can drive productivity across the UK by improving human capital and creating safe, connected places with good employment opportunities that are attractive to both live and invest in.

There are fiscal constraints that need to be considered, but it is critical that steps are taken to provide an adequate and secure funding stream for vital services which themselves generate substantial local and national economic and social benefits. This might not come from additional money, but the way that resources are allocated, pooled and invested - within and between services and places. These services should be determined and delivered by local leaders who best understand their areas' needs. In many cases, local powers are restricted by funding issues, so a more coherent approach to the devolution of public service provision is required, one which clearly defines powers and control, as well as considers the ways in which funding is provided.

How we got here

Since the end of the Second World War, public services, including healthcare and education, have played an important role in the lives of people across the country. Yet strains on these services are increasingly visible as a toxic combination of factors has simultaneously intensified demand and undermined capacity, leaving many key services dysfunctional or absent. The educational attainment gap is a national disgrace, as are our transport and health care systems, with people routinely facing rail disruption and unable to access emergency services.

A national programme of austerity saw significant spending cuts implemented through the 2010s via reductions in “lower-profile” services and capital investment as well as by suppressing public sector wages and cutting staff numbers. Local government spending and working age welfare saw some of the largest cuts, while NHS spending was largely protected. Total spending on adult education and apprenticeships fell by 38% in real-terms between 2010–11 and 2020–21, including a 50% fall in spending on classroom-based adult education.² Spending on preventative services, particularly those delivered by local councils, was also severely reduced with spend on early intervention children’s services falling by 48% between 2010–11 and 2019–20.^{3,4} Places such as Greater Manchester had begun to shift back towards more preventative spending but the challenges they have faced in doing so were only compounded by the Covid-19 pandemic, which hit the UK in 2020. This put a

¹ CPP analysis of OECD data

² Sibieta, L. et al (2022) *Plans will leave spending on adult education and apprenticeships 25% below 2010 levels by 2025* [Institute for Fiscal Studies] Available at: <https://ifs.org.uk/news/plans-will-leave-spending-adult-education-and-apprenticeships-25-below-2010-levels-2025>

³ Williams, M & Franklin, J. (2021) *Children and young people’s services: Spending 2010–11 to 2019–20*. [Bernardos] Available at: <https://www.bernardos.org.uk/sites/default/files/2021-07/Spending%20on%20children%27s%20services%20in%20England%20-%20July%202021.pdf>

⁴ Hoddinott, S. Fright, M. and Pope, T. (2022) *‘Austerity’ in public services: lessons from the 2010s*. [IFG]. Available at: <https://www.instituteforgovernment.org.uk/publications/austerity-public-services>

huge strain on our health service, councils, businesses and schools, as evidenced by the widening the attainment gap between more deprived pupils and their peers.

Government spending increased through the Covid-19 period, and was successful in preventing mass unemployment, but the pandemic's economic and social consequences were immense, exacerbating demand and compromising delivery, resulting in significant backlogs across major public services, including the NHS.⁵ Most recently, the cost of living crisis has seen spiralling costs lead to real terms funding cuts for public services. At the same time the economic consequences of rapidly rising prices are increasing the need for pivotal welfare services such as income and housing support.

Poor health is impacting the workforce more in the UK than other countries and a commitment to overhauling local public services through investment and reform could help address this and strengthen the underlying fundamentals of the economy.⁶ Bold action today has the potential to simultaneously reduce the pressure on future services, and generate productivity and economic growth for the benefit of both the public and private sector. Without it, the UK will continue to underperform, falling even further behind our G7 and EU peers.

New evidence on the health impacts of inequality

Health is a key measure of inclusive growth and previous CPP analysis found that healthy life expectancy was the leading indicator of differences in prosperity across local areas in the UK.⁷ Worryingly, progress on life expectancy in the UK has stalled, with the number of years women can expect to live in good health declining over the last decade and life expectancy stalling and then falling in recent years as the Covid-19 pandemic claimed thousands of lives.^{8,9}

Healthcare itself is important but has been found to only be responsible for between 15% and 43% of health outcomes.¹⁰ The social determinants of health – such as income, employment, education, housing and crime - account for a far larger share. Women living in better well-off regions such as London and the South East can expect to live over two years longer than those in the North East and North West. For the most deprived local authorities in England, female life expectancy is over four years less than in the least deprived authorities and has been stagnant or falling since 2012 (Fig.1).

⁵ Davies, N. et al. (2020) *Performance tracker 2020, how public services have coped with coronavirus*. [IFG]. Available at: <https://www.instituteforgovernment.org.uk/sites/default/files/publications/performance-tracker-2020.pdf>

⁶ Burn-Murdoch, J. (2022) *Half a million missing workers show modern Britain's failings* [Financial Times] Available at: <https://www.ft.com/content/b197e9e0-dd53-4d77-a84f-a94824100ed5>

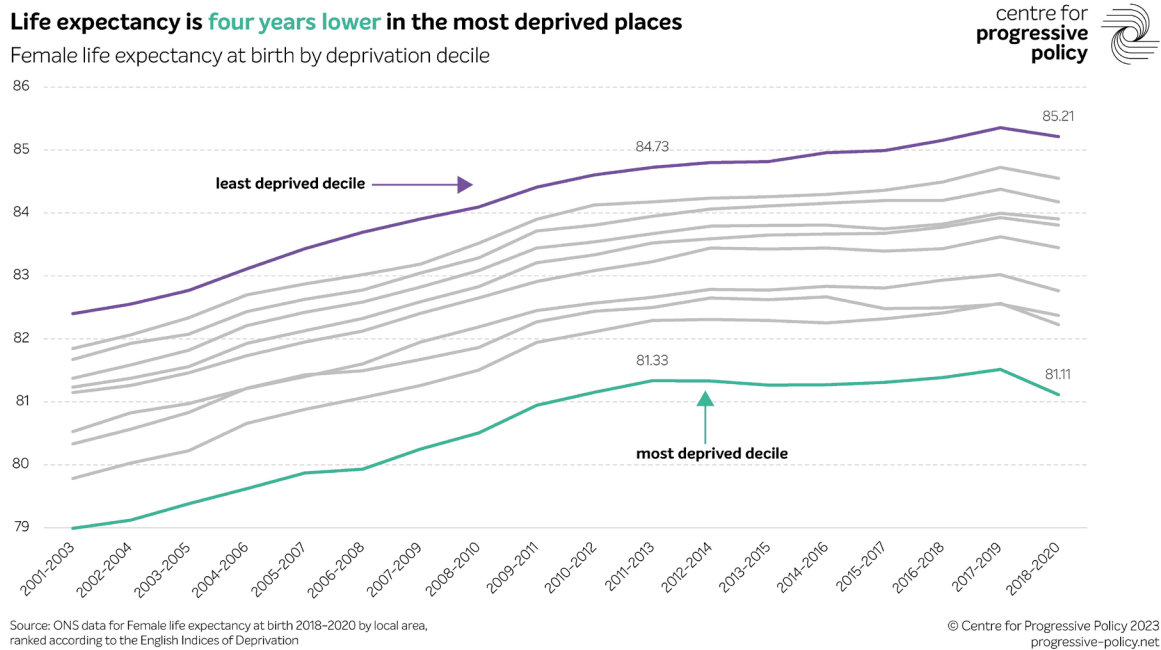
⁷ Norman, A. et al (2019) *The good life: communities*. [CPP]. Available at: <https://www.progressive-policy.net/publications/the-good-life-communities>

⁸ Tinson, A. (2022) *Healthy life expectancy target: the scale of the challenge* [The Health Foundation] Available at: <https://www.health.org.uk/news-and-comment/charts-and-infographics/healthy-life-expectancy-target-the-scale-of-the-challenge>

⁹ Official data on deaths with Covid-19 on the death certificate are available at: <https://coronavirus.data.gov.uk/details/deaths>

¹⁰ Institute of Health Equity (2017) *Voluntary Sector Action on the Social Determinants of Health*. Available at: <https://www.instituteoftheequity.org/resources-reports/voluntary-sector-action-on-the-social-determinants-of-health/voluntary-sector-action-on-the-sdoh-evidence-review.pdf>

Figure 1



New analysis by CPP finds that peoples' lives are being significantly shortened by socioeconomic inequality with over 81m life years lost due to inequality, an average of 1.5 years per person.¹¹ We have calculated the total expected number of years of life lost for the population of England due to socioeconomic inequalities and ask how many extra years men and women could expect to live if their conditions were equal to those living in the least deprived decile of local authorities. Our analysis disaggregates years of life lost by local authority and type of inequality. For example, in Sandwell, one of the most income deprived local authorities in England, we estimate that people will live around 4.4 fewer years due to higher levels of unemployment (0.7 years), lower income (0.8 years), educational disadvantage (1.9 years), higher risk of local crime (0.4 years) and poorer quality housing (0.2 years).¹²

The gap in life expectancy between places has persisted since CPP last ran this analysis in 2018; however, the balance of factors affecting life expectancy has changed, with life expectancy now less likely to vary with local unemployment levels and more likely to vary with income and relative levels of educational disadvantage and local crime (Fig 2). Overall, relative levels of educational disadvantage between places remained the strongest socio-economic predictor of life expectancy for both men and women, suggesting that policies aiming to improve long term longevity should focus on access to education and training opportunities.

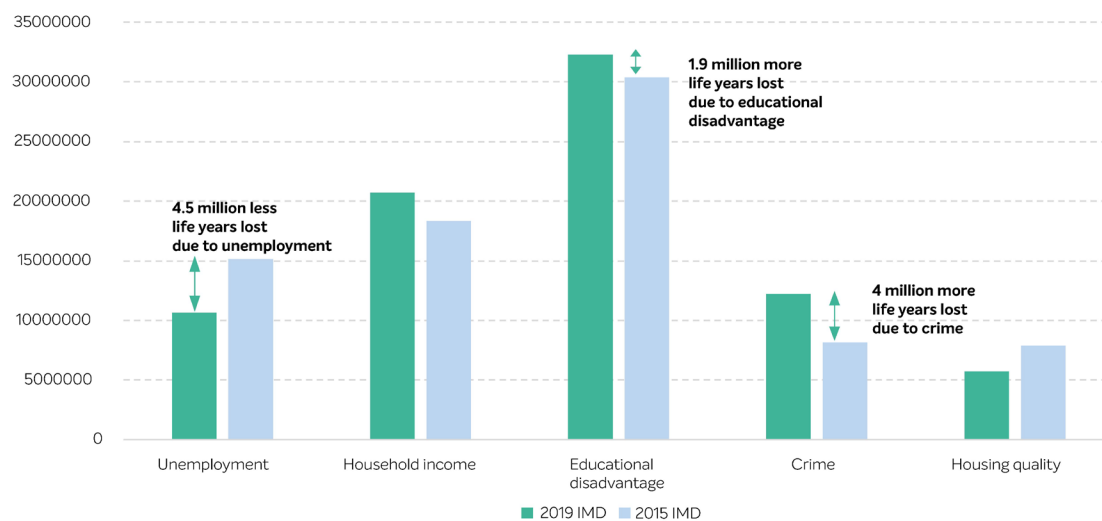
¹¹ This assumes everyone could live as long as those in the least economically deprived areas and is based on the 2019 English Indices of Deprivation, updating previous CPP work. For methodological details see: <https://www.progressive-policy.net/publications/beyond-the-nhs-addressing-the-root-causes-of-poor-health>

¹² As this analysis is cross sectional it cannot be said to demonstrate causality between the social determinants of health and life expectancy.

Figure 2

Total life years lost due to socio-economic inequality

A comparison of estimated years lost by driver in 2015 compared to 2019



Source: CPP calculations based on ONS life expectancy data and the modelled impacts of socio-economic drivers. This model uses ONS unemployment rates and gross disposable income by local authority. Educational disadvantage, crime and housing quality are based on the English Indices of Deprivation.

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Our model, which includes region and rurality as well as the drivers above, explains over 80% of the countrywide variation in life expectancy, but the actual gap in life expectancy varies considerably in certain areas. In Blackpool for example, life expectancy at birth is 6.5 years lower than in the least deprived local authorities – places like Hart in Hampshire or Rushcliffe in Nottinghamshire. Yet national relationships between life expectancy and social determinants like unemployment and income can only explain 4 years of this difference (Fig. 3). This highlights the importance of local insight and the role for local and regional government in directing local services aimed at promoting better health and productivity.

Figure 3

| Estimated life years lost due to socioeconomic inequalities in the most deprived places | | | | | | | |
|---|---------------------------------------|------|--|-------|---------|------|-------------|
| Average years lost per person | Modelled estimated years lost due to: | | | | | | Unexplained |
| | Unemployment | GDHI | Education, Skills and Training deprivation | Crime | Housing | | |
| Blackpool | 6.4 | 0.51 | 0.67 | 1.9 | 0.57 | 0.30 | 2.5 |
| Manchester | 5.5 | 0.63 | 0.75 | 1.4 | 0.75 | 0.22 | 1.8 |
| Knowsley | 4.9 | 0.29 | 0.66 | 1.9 | 0.39 | 0.20 | 1.5 |
| Liverpool | 5.3 | 0.47 | 0.68 | 1.5 | 0.54 | 0.28 | 1.8 |
| Barking and Dagenham | 3.1 | 0.64 | 0.60 | 1.5 | 0.55 | 0.14 | -0.33 |

Modelled impact of socio-economic determinants on life expectancy. Estimates are averages for men and women and are based on the 2019 English Indices of deprivation as well as ONS data on life expectancy for 2016-18, modelled unemployment estimates for 2016-17 and Gross Disposable Household Income for 2017.

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The impact of socio-economic conditions on the length of time people can expect to live in good health is even greater than on life expectancy, with people in England losing an average of 2.6 years of healthy life compared to those living in the most prosperous areas, 144 million years of healthy

life in total.¹³ This has implications for health and care services, leading to greater demand in places that are more deprived.

Educational disadvantage is a less important predictor of health than overall life expectancy and is not significant in determining female health at place level. Instead, unemployment is the leading indicator, followed by household income. While the model explains less place level variation in good health than it does in life expectancy (60%), it is clear that increasing access to good employment and reducing poverty should be another focus of a government looking to improve population health.

Reaching crisis point

Poor health has left our healthcare system vulnerable to additional pressures like Covid-19

As outlined above, the UK is in poor health and its healthcare service is visibly at breaking point, with nurses and ambulance workers recently taking strike action for the first time in the UK's history amid concerns about patient safety. Hospital capacity and flow issues mean there are a lack of usable beds for new non-Covid patients and these factors, alongside high levels of A&E attendances – in part due to failures across the wider system of public services – are contributing to record A&E waiting times.^{14,15}

Growth in emergency admissions to hospitals far outstrip population growth and – alongside Covid legacy issues like low immunity levels to flu and other common illnesses following lockdown – is related to a long term build-up of poor health with patients having complex needs. For example, there has been an increase in older patients and patients with multiple health conditions needing to be admitted to hospital with one in three patients admitted to hospital in 2015/16 having five or more health conditions.¹⁶ Having three or more health conditions is known as complex multimorbidity and is associated with the need for assistance. It is both more common for less wealthy people and is growing amongst younger populations in England.¹⁷

Compared to other countries, England is highly exposed to air pollution, high cholesterol and low levels of physical activity, in part due to decades of poor urban planning policy.¹⁸ All of these risk factors are more prevalent amongst more deprived parts of the population – previous CPP analysis shows that prior to the pandemic, income levels explained 30% of the variation in obesity across

¹³ Based on Healthy Life Expectancy data for 2016–2018. Data for some district councils is imputed based on county council data.

¹⁴ Burn-Murdoch, J. (2022) *The real reason for the NHS crisis* [FT] Available at: <https://www.ft.com/content/2ee16591-a973-4f9f-93e3-3ec6db66cf48>

¹⁵ The King's Fund (2022) *What's going on with A&E waiting times?* Available at:

<https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters>

¹⁶ Gardner, T. et al (2018) *Emergency hospital admissions in England* [The Health Foundation] Available at:

<https://www.health.org.uk/publications/emergency-hospital-admissions-in-england-which-may-be-avoidable-and-how>. Data is from NHS England (www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity). In some instances, it was necessary to supplement this with analysis of more detailed Hospital Episode Statistics data

¹⁷ Singer et al (2019), *Trends in multimorbidity, complex multimorbidity and multiple functional limitations in the ageing population of England, 2002–2015*, Journal of Multimorbidity and Comorbidity. Available at:

<https://journals.sagepub.com/doi/10.1177/2235042X19872030>

¹⁸ Schmidt, J. et al. (2020) *The Burden of Disease in England compared with 22 peer countries*. [Public Health England] Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856938/GBD_NHS_England_report.pdf

England.¹⁹ Poor diet and low levels of physical activity are leading risk factors for obesity which significantly increases the risk of other diseases.²⁰ These risk factors have a social gradient and during the recent Covid-19 pandemic, the ONS found that Covid related mortality in the most deprived areas of England and Wales was significantly higher than in less deprived places.²¹ We are now seeing record numbers of people out of the labour market due to ill health with some of the highest levels of inactivity in the most deprived regions such as the North East. This trend is being driven by those increasing numbers suffering from multiple long-term health conditions, predominantly related to chronic pain or mental health.²²

Amidst increasing pressures, unsustainable working conditions are leading to a mass exodus of staff.

Turnover has long been an issue in the social care sector which routinely does not pay enough to live on - the Joseph Roundtree Foundation finds that half a million health and social care workers are living in poverty.²³ Demand for adult social care staff and the number of unfilled vacancies both reached record highs in 2021/2022 and it is widely acknowledged that the resulting under provision of social care is causing backlogs in emergency services as - mostly elderly - patients are forced to stay in hospital beds because they have nowhere else to go.²⁴ The same is true for community trust roles like district nursing and care trusts providing health and care services for the elderly, which have seen the highest average nurse leaver rates - 16.8% and 14.7% respectively in the year to June 2022.²⁵ As well as keeping patients in hospital, shortages in these sectors mean that health problems are not addressed early enough, leading to more patients presenting in A&E later down the line.

Over the past year, the issue of staff shortages has intensified in NHS professions, partly due to burnout from working during the pandemic period. Record numbers of nurses are resigning, and The King's Fund found that two thirds of NHS nurses leaving their role between 2021 and 2022 were under 45 years of age.²⁶ Nurses also voted to strike on pay for the first time ever in November 2022.

Dissatisfaction in these roles is being caused by real terms pay cuts alongside high workloads. Maternity staff overwhelmingly suggested better terms and conditions as the short term solution to staffing shortages, in particular, backdating pay to eliminate real terms cuts, more flexible working arrangements to support staff health and wellbeing as well as more financial incentives for

¹⁹ Franklin, B. (2020) *The business case for investment in public health and obesity* [CPP]. Available at:

https://www.progressive-policy.net/downloads/files/CPP_social-infr_publ-health-and-obesity.pdf

²⁰ Everest, G. et al. (2022) *Addressing the leading risk factors for ill health*. [The Health Foundation] Available at:

https://www.health.org.uk/sites/default/files/upload/publications/2022/Risk%20factors_Web_Final_Feb.pdf

²¹ ONS data on Deaths involving COVID-19 by local area and socioeconomic deprivation is available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvedcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31july2020>

²² Burn-Murdoch, J. (2022) *Half a million missing workers show modern Britain's failings* [Financial Times] Available at:

<https://www.ft.com/content/b197e9e0-dd53-4d77-a84f-a94824100ed5>

²³ The Joseph Roundtree Foundation (2022) *UK Poverty 2022: The essential guide to understanding poverty in the UK*.

Available at: <https://www.jrf.org.uk/report/uk-poverty-2022>

²⁴ Skills for Care (2022) *The state of the adult social care sector and workforce in England*. Available at:

<https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

²⁵ Palmer, B & Rolewicz, L. (2022) *Peak leaving? A spotlight on nurse leaver rates in the UK*, The Nuffield Trust, Available at:

<https://www.nuffieldtrust.org.uk/resource/peak-leaving-a-spotlight-on-nurse-leaver-rates-in-the-uk>

²⁶ Holmes, J. (2022) *The NHS nursing workforce - have the floodgates opened?* [The King's Fund] Available at:

<https://www.kingsfund.org.uk/blog/2022/10/nhs-nursing-workforce>

training.²⁷ NHS leaders have suggested that health professionals like midwives and GPs often spend a lot of time doing tasks that could be undertaken by those with less training, contributing to their unsustainably high workloads. Improving service management and administration and reallocating less specialised work away from frontline staff could help to improve working conditions and meet demand without the need to train ever more medical staff.²⁸

A new approach to resourcing places is needed.

The fiscal environment requires the government to think differently about allocating resources. High interest rates and a low growth outlook are contributing to a constrained fiscal environment with a high cost of borrowing. Public spending should be prioritised based on need and spent effectively.^{29,30}

Prior to the pandemic, the OBR identified healthcare spending as the primary risk to the UK's long term fiscal sustainability – acting on prevention is vital as better health will reduce demand for complex and expensive health and care services and enable greater participation in the labour force while longer lives increase incentives for individuals to invest in their own skills and education.³¹ To improve health outcomes, the government needs to spend money on preventative public health capacity rather than ever increasing amounts on treatments, as this is clearly not working to improve the time people spend in good health. Analysis by Professor Ben Barr and others has shown the positive relationship between local government spending and health. Spending cuts to preventative children's services preceded higher acute spend on children being taken into care, particularly in more deprived places.³² This demonstrates that cuts to preventative services are a false economy and speaks to the need for a life-course approach to health.³³

The NHS Confederation estimates that NHS spending on obesity is forecast to rise to £9.7 billion per year by 2050 and malnutrition is estimated to cost the NHS £19.6 billion per year.³⁴ Depression, stress and anxiety are also major sources of poor health and have a negative impact on productivity. These conditions are exacerbated by financial and housing insecurity, underlining the importance of broad-based policy solutions that recognise the interrelation between these issues.³⁵ More severe

²⁷ Baby Loss and Maternity All Party Parliamentary Groups (2022) *Safe Staffing: The impact of staffing shortages in maternity and neonatal care* [https://sands.org.uk/sites/default/files/Staffing%20shortages%20-%20APPG%20report.%20Oct%2022%20\(final\).pdf](https://sands.org.uk/sites/default/files/Staffing%20shortages%20-%20APPG%20report.%20Oct%2022%20(final).pdf)

²⁸ Kirkpatrick, I. et al (2022) *Is the NHS overmanaged?* [NHS confederation] Available at: <https://www.nhsconfed.org/long-reads/nhs-overmanaged>

²⁹ Ogden, K. et al. (2022) *Does funding follow need? An analysis of the geographic distribution of public spending in England*. [Institute for Fiscal Studies]. Available at: <https://ifs.org.uk/publications/does-funding-follow-need-analysis-geographic-distribution-public-spending-england> Basing allocations on variation in spend since 2015 discounts unmet need in this period, a time when services were being cut.

³⁰ Sandford, M. (2021). *Reviewing and reforming local government finance* [House of Commons]. Available at: <https://researchbriefings.files.parliament.uk/documents/CBP-7538/CBP-7538.pdf>

³¹ Office for Budgetary Responsibility (2019) *Fiscal risks report* Available at: https://obr.uk/docs/dlm_uploads/Fiscalrisksreport2019.pdf

³² Barr, B. et al. (2021) *What did local government ever do for us?* Available at: <https://pldr.org/2021/09/30/what-did-local-government-ever-do-for-us/>

³³ As has been adopted in places such as Blackburn with Darwen as part of their health and wellbeing strategies since 2018. For detail see: <https://www.blackburn.gov.uk/sites/default/files/media/pdfs/UA-BwD%20Health%20and%20Wellbeing%20Strategy.pdf>

³⁴ Lowe, R. & Mahmood, H. (2022) *Why preventing food insecurity will support the NHS and save lives* [NHS Confederation] <https://www.nhsconfed.org/long-reads/why-preventing-food-insecurity-will-support-nhs-and-save-lives>

³⁵ Clark, T. and Wenham, A. (2022) *Anxiety nation? Economic insecurity and mental distress in 2020s Britain* [The Joseph Rountree Foundation] Available at: <https://www.jrf.org.uk/report/anxiety-nation-economic-insecurity-and-mental-distress-2020s-britain>

mental illness also has a high cost to the taxpayer, with emergency police callouts to incidents involving people suffering a mental health crisis increasing 41% between 2015 and 2020.³⁶ Community mental health services are associated with lower costs of care and fewer deaths by suicide.³⁷ Spending on early intervention and prevention therefore needs to be seen as an investment in people that can boost long term productivity as well as improve wellbeing and save lives.

CPP analysis of 35 OECD countries since 1980 shows that those countries which increased their spending on social protection and education as a proportion of GDP also experienced improvements in health (measured in terms of life expectancy and infant mortality). The evidence base supports social and economic determinants as the most significant influencing factors on the patterns and prevalence of ill health in populations and yet it remains chronically under-valued.³⁸ Public expenditure statistics for the UK in the run up to the pandemic show that key levers for the social determinants of health - such as education, social protection, and housing - have been deprioritised since 2010 (Fig.4) This is unsustainable - the only thing we've protected is healthcare, yet our health is not improving.

Figure 4

Change in UK public spending in the run up to the pandemic

Cumulative change by function (1998-2020)



Source: CPP analysis of .HTM Public Expenditure Statistical Analyses (PESA) 2022, Table 4.3 Public sector expenditure on services by function in real terms, 1998-99 to 2021-22

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Addressing complex challenges like economic productivity and poor health requires an approach that is tailored to individual communities and many preventative services are delivered by local authorities. The government must support local systems – spanning NHS, local and combined authorities, and other partners – to deliver effective population health, aligned with wider local economic and social policy priorities.

³⁶ Campbell, D. (2020) *Police 999 callouts to people suffering mental health crises soar* [The Guardian]. Available at: <https://www.theguardian.com/society/2020/oct/18/police-999-callouts-to-people-suffering-mental-health-crises-soars>

³⁷ Simmonds et al (2018), *Community mental health team management in severe mental illness: A systematic review*, [The British Journal of Psychiatry] Available at: <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article-mental-health-team-management-in-severe-mental-illness-a-systematic-review/3495689C90F0970C598D1B67A425D621>

³⁸ Franklin, B. et al (2018) *Beyond the NHS* [CPP] Available at: <https://www.progressive-policy.net/publications/beyond-the-nhs-addressing-the-root-causes-of-poor-health>

The combined authority in Greater Manchester has demonstrated the potential benefits of a joined up local approach. Since devolution in 2014, life expectancy across the authority has grown more than expected, with benefits being particularly apparent in areas of high deprivation. Tentative evidence suggests that these improvements are likely due to better coordination across sectors and care services.³⁹

The North of Tyne (NTCA) has also made notable progress on integrating health and wider economic policies. In 2022 they became the first combined authority to adopt a wellbeing framework, designed by their Inclusive Economy Board, to identify the outcomes and indicators the authority should focus on.⁴⁰ The framework pushes NTCA's policy decisions to be reviewed in light of whether they increase access to good quality jobs, homes, and health and care services and reduce poverty. The authority has also piloted cross-cutting approaches that aim to tackle poverty by increasing access to services, such as bringing welfare rights into school settings and are using the Community Hubs Investment Fund to support organisations that provide a range of services under one roof.⁴¹

However, tensions currently exist between different points of local leadership and accountability. The NHS will deliver exactly what it is incentivised to by targets and funding and has not yet systematically demonstrated that it can operate under the kind of joint accountability that would be required for cross-agency working on issues such as mental health. The introduction and expansion of place-based convening organisations like Integrated Care Systems and Mayoral Combined Authorities provide a rare opportunity to facilitate such an approach which should not be wasted. New policies should build on the emerging local and regional population health architecture to facilitate the maturity of ICSs and their integration with MCAs, county councils and any other public service delivery structures and boundaries.

CPP's next paper will consider the role for national policy in this space, including how tensions of responsibility between national and local government can be addressed.

³⁹ Britton, P. et al (2022) *The effect of devolution on health: a generalised synthetic control analysis of Greater Manchester, England*. [The Lancet] Available at: [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(22\)00198-0/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(22)00198-0/fulltext)

⁴⁰ Thurman, B. et al (2022) *Wellbeing Framework for the North of Tyne* [Carnegie UK] Available at: <https://www.northoftyne-ca.gov.uk/wp-content/uploads/2022/01/Wellbeing-Framework-for-the-North-of-Tyne-full-report-Jan-22.pdf>

⁴¹ For more information see: <https://www.northoftyne-ca.gov.uk/what-we-do/our-communities>

Written and researched by Rosie Fogden

Designed by Raquel Aguirre

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About the Centre for Progressive Policy

The Centre for Progressive Policy (CPP) is an economic think tank that champions inclusive economic growth. We publish research, analysis and practical policy solutions to make this model of growth a reality, working with local and national partners.

Centre for Progressive Policy

27 Great Peter Street
London SW1P 3LN

+44 (0)20 7070 3360
www.progressive-policy.net

