Assessing the Impact of the Economic Downturn on Health and Wellbeing

February 2012

Lyn Winters, Sharon McAteer and Alex Scott-Samuel
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Liverpool Public Health Observatory

Liverpool Public Health Observatory was founded in 1990 as a research centre providing intelligence for public health for the five primary care trusts (PCTs) in Merseyside: Liverpool, Halton and St Helens, Knowsley, Sefton and Wirral. It receives its core funding from these PCTs.

The Observatory is situated within the University of Liverpool's Department of Public Health and Policy. It is an independent unit. It is not part of the network of regional public health observatories that were established in 2000 - though it was acknowledged as their inspiration in the White Paper (Saving Lives - Our Healthier Nation) which launched them.
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Executive Summary

Background
Liverpool Public Health Observatory (LPHO) was commissioned to produce a report on the health impact of the economic downturn. Through a literature review and analysis of key indicators the report assesses the evidence base for the impact of the economic downturn on mental and physical health and use of health and local authority services in the five Merseyside PCTs: Knowsley, Halton and St Helens, Liverpool, Sefton and Wirral. Included in the report is an assessment of effective interventions likely to aid local services in helping their population cope with the effects of the economic downturn. This research will inform commissioning of the likely future service needs.

Aims and Objectives
To understand the likely impacts of recession on health and in particular the impacts of this economic downturn such as changes in welfare and housing benefits and reductions in public sector spend; to identify local examples of good practice and include interventions which are known to mitigate the impacts; to develop a set of core indictors which all areas can monitor over time.

Methods
The project was managed by a working group representing the five Merseyside PCTs and Liverpool Community Health NHS Trust, with specialist support from the programme leads for mental health and for employment and skills management. While there was insufficient time to complete a systematic literature search and analysis, a wide range of information and sources has been used in compiling this report.

Why this recession is different from others
The UK economy officially entered into recession in June 2008, since when it has only had limited growth. Many studies have looked at the impact of previous recessions to predict the likely impact on health of the current economic downturn. However, it has been noted that there are four key differences now to previous economic recessions:

A diminished safety net for the unemployed. Although the economy is now officially in recovery, the effect of the recession may be prolonged. Indeed, Britain could face many more years of severe austerity to balance the country’s finances. During the financial year 2010-11, earnings, state benefits and tax credits all fell in real terms. It is estimated that this has led to a fall in median net household income of 3.5%, the largest single-year drop since 1981, returning to its 2003-04 level. The decline in average living standards looks set to continue for many years to come.

New unemployment co-exists with significant structural worklessness in the form of long-term sickness absence and disability pension receipt.

The nature of work has changed within Britain during the last twenty years. A decrease in industrial employment and an increase in the size of the service sector accompanied by an increase in shift work and flexible, precarious employment with limited or no employment or welfare rights. This carries a high risk of unemployment, often without redundancy packages. Furthermore, a daily existence of low paid, high-strain, temporary employment will result in ill prepared people who are minimally resilient in the face of the additional negative health impact of unemployment.
The labour market is becoming increasingly feminised and gender roles are shifting. Therefore, the negative effects of unemployment may be more equally experienced by women and men.

Mechanisms causing health impacts
Evidence from a recent literature review suggests that through the economic downturn there are three main intervening mechanisms causing health impacts: stress, frustration-aggression and ‘effect budgeting’. Declining economies increase the incidence of stressful job and financial events and increase the anticipation of stressful experiences such as job loss and financial difficulties. The much tested frustration-aggression argument predicts that contracting economies can increase the perception of unfair loss of earned rewards, and increase the incidence of intrafamily and workplace violence as well as substance abuse. However, it could also have an inhibiting effect on violence and substance misuse, as workers who fear job loss will do whatever they can to avoid it. A declining economy not only reduces the money available to many households, but also forces them to invest time and effort in managing the sequelae of lost jobs or lost income - taking time, energy and money away from other investments, such as exercise, socially supportive behaviours, good nutrition etc. This has also been described as “time poverty”.

Local areas have very low economic resilience
The downturn will impact in different ways upon businesses, individuals and communities, in that some will be more economically resilient or vulnerable than others to shocks in the external environment. For example, research by the Centre for Cities in January 2011 shows that Liverpool Primary Urban Area (an aggregate of Knowsley, Liverpool and St Helens) is in the top four cities projected to suffer the highest public sector job losses; Wirral and Liverpool PUAs have the highest welfare bill of all PUAs in England.

Social support can be protective, but can be tested in economic downturns
Social support, social networks and social cohesion can make people more resilient to an economic crisis. From evidence of previous recessions, the adverse health effects of rapid economic change were reduced substantially where many people were members of social organisations such as trade unions, religious groups or sports clubs illustrating the protective effects of social support. However, the economic crisis is probably increasing the social exclusion of vulnerable groups as they may have to sacrifice social activities.

Certain vulnerable groups are less resilient to this economic downturn
A study for the Joseph Rowntree Foundation (JRF) looking into how people in the UK are coping with poverty during the aftermath of the current recession, shows that adapting to the rising cost of living creates a considerable stressful burden by having to economise on food, heating and travel, spending more time and effort on shopping and cooking, whilst having less nutritious food. Such effects occur disproportionately among people with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.

Cuts in public spending are affecting services that promote long-term health and well-being (such as: adult social care, libraries, community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly. There is also
substantial evidence that poverty is both a determinant and a consequence of mental health problems.

Overview of the health impacts

A widening of health inequalities is predicted
The study by the JRF into people coping with poverty at the start of the recovery, before the cuts to public sector services and the introduction of welfare reform, found that for some the recession has meant worse diets, colder homes and less physical mobility, as they have been unable to adjust their spending without harming their well-being, with potentially longer-term impacts on health.

Fuel poverty
The elderly, disabled, babies, children and adolescents are more susceptible to the effects of fuel poverty, as households attempt to make savings by reducing fuel costs through self rationing and disconnection. Fuel poverty is increasing in all areas covered by this report, with Liverpool having consistently higher rates than other areas, from nearly 16% of households in 2006 to over a quarter in 2009. The majority of households in fuel poverty are consistently in the lowest income groups, but with rising energy costs, more households with higher incomes are being pushed into fuel poverty. Since the start of the economic downturn CABs have seen a huge increase in people coming for help because they are unable to pay their gas and electricity bills.

Cold homes and damp and/or mould growth are key determinants of poor health. Fuel poverty is linked to respiratory and cardiovascular disease, to exacerbating existing health problems such as asthma, bronchitis and arthritis (that can lead to accidents through stiff joints) and causing mental ill-health. It also increases the likelihood of minor illnesses such as colds and flu. Excess winter deaths are three times as high in the coldest homes as in the warmest. Children living in cold homes are more than twice as likely to have respiratory problems as children living in warm homes. A quarter of adolescents living in cold housing have mental health problems. This is five times the proportion among adolescents who have always lived in warm homes.

Older people
The combination of the house-price slump, the reduction in pension values, the loss of interest on savings, in addition to the rising cost of utilities bills and the price of food means that many older people have reduced household budgets. They will therefore be at risk of fuel poverty and poor diet, with all the associated health impacts.

Children and young people
Mental health
If parents or guardians lose their job then the economic impact of this could constitute a risk factor for the longer-term mental health of their children.

Education
Efficiency savings in schools could affect the level of teaching support and adversely impact on classroom behaviour and exam results. There will be a disproportionate effect on children from disadvantaged backgrounds not being able to access higher education.
Poverty
It is predicted that absolute and relative child poverty will increase through government changes to personal taxes and state benefits. The Children’s Society is concerned that after Universal Credit is introduced in 2013 around 100,000 disabled children will lose up to £27 per week.

Mid-year estimates for 2010 put Liverpool within the top 20 Local Authorities (LAs) with highest levels of child poverty across England. In one Liverpool parliamentary constituency nearly half of all children resident are living in poverty.

High unemployment amongst young people
During July-September 2011 1.02 million 16-24 year olds were out of work. Young people are particularly badly hit by unemployment and can suffer from the long-term ‘scarring’ that can occur after such a bad early experience with the labour market. This can have a lasting adverse effect on employment prospects and future earnings particularly for low-skilled or those not in education or training. Young unemployed people have a higher risk of getting mental health problems, such as depression, than young people who remain employed. Attempted suicides are up to 25 times more likely for unemployed young men than for those in jobs.

Disabled people
It is estimated that between 50-60% of disabled people live in poverty and they are particularly vulnerable to cuts in public sector services. What level of support a disabled person is entitled to can have life changing implications. Knowsley is the best LA in England in terms of provision and access to welfare services for disabled people, despite being the eighth most deprived area in the country. By combining services from Health and Social Care together and joint commissioning it has been able to protect its disabled population from the worst of the cuts and has given the authority an opportunity to make cost savings.

Women and single parents
Women are suffering from cuts to their jobs, benefits and services that support women’s everyday lives. The measures are undermining women’s hard won rights to protection from violence and access to justice, as the Ministry of Justice plans to save £350m a year from the legal aid budget. There is a growing likelihood that women will be the ones left ‘filling the gaps’ as state services are withdrawn. It is those who have the least to lose that will lose the most: women who are unemployed or on low incomes, pregnant women, families, single mothers and pensioners, victims of sexual, domestic or other violence. Many of the spending cuts will have a disproportionate impact on women and will lead to greater inequality between women and men.

Ethnic minorities
Ethnic minorities tend to be concentrated in sectors of the economy where the long-term decline in employment has been accelerated by the recession. Also, spending cuts in the public sector may have a disproportionate effect on ethnic minority groups, because this is a sector where they are disproportionately employed. Black, black British and mixed race young people have seen the biggest increases in unemployment. Nearly half of black and black British 16-24 year olds are unemployed a rate that has increased by nearly 13% since the start of the recession. As in previous recessions in the 1980s and 1990s, minority unemployment may stay relatively high for a long time after an economic recovery.
Impacts on physical and mental states
Studies have consistently shown that unemployment, which increases in economic downturns, is linked to poorer health. The links between poorer health have been explained through the psychological effects of unemployment (e.g. stigma, isolation and loss of self-worth) and the material consequences of a reduced income. Along with poorer mental health there is a reported decline in self-reported health and an increase in limiting long-term illness. However, there is some counter evidence which suggests that some chronic conditions and acute morbidity may actually decrease during economic recessions. Rapidity of economic change appears to be a key hazard to health. The direction of change seems less important.

Cardiovascular disease
Risk factor studies from America suggest that undesirable job and financial experiences will increase the risk of acute cardiovascular disease (CVD), nonspecific morbidity, and mortality later in life. Emotional states associated with job loss, including anxiety and depression, may influence CVD through excessive activation of stress response pathways, particularly for the long-term unemployed or who enter into a cycle of low paid insecure employment.

Mental health
The strongest negative effect of an economic downturn is on mental health. There is consistent evidence that the economic downturn may increase suicide and alcohol-related death rates, which can be seen as markers of deterioration of mental health - although suicide rates in England and Wales may be underestimated, as since 2001 narrative verdicts are increasingly being used. The majority of new disability claims are on the basis of mental health. Mental health can develop as co-morbidities among those initially out of the labour market through physical conditions.

Those still in work but suffering from job insecurity may experience mental health effects that reduce productivity, through stress, anxiety and depression-related disorders. Worries about job losses have made stress the most common cause of long-term sick leave in Britain with employers planning redundancies most likely to see a rise in staff mental health problems. Stress in the public sector is becoming a particular challenge through the sheer amount of major change and restructuring. At the same time there is a slowing in the jobs market. With the fear of being targeted for redundancy schemes over a quarter of employees are struggling into work when sick, according to a CIPD survey of nearly 2 million workers.

People suffering from financial strain will be particularly at risk of mental health problems.

Health behaviours
The extent to which economic changes impact on health behaviours depends on the extent to which people are protected from harm from risk factors such as cheap availability of alcohol and the dominant culture. In some studies unemployment is linked to a higher incidence of risky health behaviours, in particular among young men including problematic alcohol use and smoking. In western countries there is an association between economic downturns and worsening diets as people try to save money with cheap junk food.
Are there any positive impacts of the economic downturn?
There may be increased opportunities for leisure time as job pressures and working hours reduce. How people deal with difficulties like unemployment in times of economic crisis depends on their coping mechanism. If struggling with an inadequate income opportunities for using leisure time will be limited. However, reductions in income can lead to a reduction in hazardous health behaviours and car accidents and traffic fatalities decrease. A quarter of people surveyed have reported growing their own fruit and vegetables which can have a positive impact on mental health.

The adverse effects of a recession are reduced where many people are members of social organisations such as trade unions, religious groups or sports clubs illustrating the protective effects of social support. Informal social welfare can provide people with a place to turn to for support whether to borrow money, or to supply food or shelter or to get advice on sources of help. The crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient.

There is some evidence to suggest that some chronic conditions and acute morbidity may actually decrease during economic recessions. Whether these are substantive impacts or represent increased / enforced tolerance to morbidity remains to be established.

Impact on public services through the economic downturn
Evidence suggests mental health problems are causing a surge in anti-depressant prescriptions in England, particularly in the North of England due to a rapid rise in unemployment. There has also been an increased use of specialist mental health services during 2009/10. This includes an increase of 30.1% from 2008/9 in the number of people being detained in hospital under the Mental Health Act.

Also, the under-funding of adult social care could increase hospital admissions, due to cuts in local authority provision. Furthermore, there may be further increases in alcohol related hospital admissions.
Recommendations to Local Authorities, Commissioners and Service Providers

To minimise the effects of reduced public services:

- At the very least plans for cuts should be assessed and monitored for their likely health impact on equality and human rights, vulnerable groups and neighbourhoods
- Ensure co-ordination of policies and practices, where multiple agencies have an impact on a particular issue
- Be aware that there will be long-term impacts of the recession even when entering the recovery
- Fully understand your economy, and the impact of the recession on businesses, people, capital developments and demand for services;
- work with local partners, business leaders, property developers, neighbouring authorities and regional bodies to gather intelligence and agree a strategic response; and
- Implement a strategy that has clear objectives, is tailored to local issues and focuses on both the social impact and the future recovery.
- Consider using a ‘whole area’ Total Place approach to public services to shield areas from the economic downturn - this can lead to better services at less cost such as Hull’s ‘Place Shielding Action Plan’
- Consider integrating lifestyle/prevention services into whole person centred wellness services.
- Improve information on local provision: To record standardised performance metrics, establish guidelines for setting benchmarks and advocate good practice locally.
- Increase knowledge of what works: Ideally to establish an anonymous database of the cost effectiveness of interventions (as maintained by NICE in the healthcare sector) and publish standard guidelines on what data funders should track to encourage the analysis and dissemination of best practice.

To mitigate the mental health effects of the economic crises consider:

- Using active labour market programmes to enable the unemployed to find work
- Encouraging employers to develop strategies and approaches that address uncertainty, anxiety and job stress.
- Family support programmes to protect low income families from further economic strain.
- Community support agencies to be adequately resourced to help people overcome problems arising from job loss, debt, and mortgage arrears.
- Improved access to affordable sources of credit by supporting credit unions or their development.
- Better regulation of bailiffs. All statutory agencies that use bailiffs to include disability equality duty specifications in their procurement contracts.
- Training for health and social care professionals so that they can identify debt triggers and sources of help for money problems.
- Encouraging health and social care professionals to work with creditors and debt advisers when supporting clients who are experiencing problem debt
- Having advisers who are able to provide information about debt and welfare benefits to be based at GP surgeries and hospital clinics
Development and dissemination of a guide to money management for people with mental health problems to be distributed through GP surgeries, hospitals, community health services and third sector mental health organisations.

Social prescribing approaches to be explored - for instance, offering welfare advice on prescription, or gardening on prescription to improve mental health problems and wellbeing.

Improved access to money and debt advice services.

Primary care for the people at high risk of mental health problems – providing psychological support and promoting problem-solving skills to modify the effects of unemployment and indebtedness.

Control of alcohol prices and availability.

Consider the following examples of good practice that promote social relationships:

- Interventions that support family and early years e.g. Sure Start
- Strengthening the home learning environment and adolescent transition
- Building social capital for children and older people e.g. liveable streets, stop and chat spaces
- Reducing environmental barriers to social contact: reducing motor vehicle traffic access to green, open spaces; affordable, accessible public transport
- Asset sharing e.g. through co-production, social return on investment measures, credit unions, social enterprise
- Protecting / reclaiming public space e.g. challenging restricted use of public areas like shopping malls in Business Improvement Districts; landshare schemes to open up land for community cultivation or bringing together those with gardens and those without, collective opportunities for healthy lifestyles e.g. social prescribing / community referrals; green gyms, food production/distribution, life long learning

To lessen the impact on disabled people and those at risk of chronic ill-health apply the following principles:

- Involve service users in designing and planning their services and in some cases delivering it can lead to improved outcomes at lower costs.
- Take a capabilities approach to disability by looking at people’s strengths and promoting what they can do.
- Implement a strategy of progression or ‘just enough support’ – where people gradually rely on less formal services and more community-based services may improve independence and quality of life whilst reducing costs.
- A move towards more integrated services can significantly reduce cost in administrative and back office functions as well as improving outcomes by creating more seamless and jointly commissioned packages of care.
- A commitment to personalisation, designing and planning services around the individual and giving people choice and control over their support are necessary to the development of principles above.
- Outsourcing – creating arms length trading organisations to deliver care services independently from the council to allow innovation and efficiency, while returning dividends to the local authority.
- Gathering data and conducting impact assessments to enable an accurate picture of how many disabled people live in an area, where they live and what services they rely on. Ensures the cumulative impact of the full range of local cuts is
considered in relation to the wellbeing, social inclusion and independence of disabled people.

- Consider carrying out a thorough and full consultation when considering cuts to services, or changes to eligibility criteria

**To lessen the impact on deprived neighbourhoods:**

- Sustain the recent gains in neighbourhood conditions from regeneration
- Provide LA and partnership schemes to help low-income home-owners with house maintenance. In partnership with owners provide: advice, training and schemes such as handy people, discounts and tool loans that could prevent home and area decline.
- Maintain neighbourhood renewal activities
- Maintain and expand the following services:
  - local job creation – encouraging use of local labour; allowing people to work for voluntary organisations whilst claiming benefits
  - employment and training support
  - services for young people
  - public and semi-public transport
  - crime prevention activities
- Consult on difficult issues
- The health sector, local authorities and the third sector to identify mechanisms which pool resources across localities for maximum health benefit.

**To help young people, particularly those ‘Not in Education, Employment or Training’ (NEET):**

- Reform commissioning: Provide improvements in commissioning through:
  - Better collaboration between local authorities and service providers
  - Greater focus on value by developing commissioning capabilities
  - Creating local markets for NEET services
  - Adopting standard processes to reduce administration
- Grow the best provision: To create more networked commissioning and business support for the best providers.
- Foster better links into employment: The school curriculum needs to prepare young people for the world of work through better links, high quality work experience and more routes into work e.g. apprenticeships. Make it easier for employers to engage with young people, particularly those most at risk of becoming NEET.
- Support targeted case management for those most at risk as many children face a challenging pathway through numerous services and interventions; an integrated case management approach is needed to improve coordination
- Protect and develop services intended to support vulnerable children and young people into employment, training and education.
- Those who are NEET and children with significant social needs may require more intensive and targeted support.

**Consider action to protect against food poverty and fuel poverty during the economic downturn:**

- Provide access to reasonably priced fruit and vegetables such as: ‘bag a bargain’ schemes and Knowsley ‘veggy van’ service
• Targeted information and ideas on how to retain a balanced diet on a low budget have been provided in children's centres and this is also an approach that might be extended to the wider community using community food workers.
• Gardening on prescription may encourage people to source their own fruit and vegetables whilst also helping to combat depression, anxiety and low moods.
• Ensure there is advice available to people at risk of fuel poverty (see the example Liverpool Healthy Homes Programme).
Introduction

Liverpool Public Health Observatory (LPHO) was commissioned to produce a report on the economic downturn. The report assessed the evidence base for the impact of the economic downturn on mental and physical health and use of health and local authority services in the five Merseyside PCTs: Knowsley, Halton and St Helens, Liverpool, Sefton, Wirral. Included in the report is an assessment of effective interventions likely to aid local services in helping their population cope with the effects of the economic downturn.

This research will inform commissioning of the likely future service needs.

Aims

- To understand the likely impacts of recession on health
- To understand the impacts of this economic downturn in particular e.g. changes in welfare and housing benefits and reductions in public sector spend
- To quantify these impacts
- To identify local examples of good practice
- To review the evidence base (taking new Horizons Confident Communities as a starting point) for interventions which are known to mitigate the impacts where appropriate

Objectives

- To review the available literature of health impacts of recession, long-term unemployment and job instability (using current known reviews as a starting point)
- To investigate the feasibility of developing a set of indicators which enable a quantifiable assessment of impact and produce a baseline report, having gathered relevant data
- To include a literature review of effective interventions to mitigate the impacts identified.

Methods

The work consisted of an evidence review of:

- Impacts of recession on mental & physical health & wellbeing
- Local level interventions i.e. not government policy level, that can support local people in mitigating or dealing with the consequences of the current economic downturn.

The process was managed by a working group consisting of a representative of each PCT taking part and also Liverpool Community Health NHS Trust, plus ‘specialist’ input from people who have particular expertise in the areas likely to be covered (see list in next section).

This work focused on an evidence review of:

- Impacts of recession on mental & physical health & wellbeing with an emphasis, where possible, on quantification of this impact and its effects on how people use
services differently e.g. if unemployment rises by x% what impact does that have on mental wellbeing and in turn on prescribing of antidepressants or use of debt advice services.

- Local level interventions and service delivery models i.e. not government policy level, that can support people in mitigating or dealing with the consequences of these impacts.
- Where the evidence permits, inclusion of impacts on different groups (taking care not to duplicate work already done for the mental health needs assessment, but potential to utilise this in a different way if appropriate).

Starting with known reviews and suggested literature from the working group and colleagues, key references in reviews were followed up and where there was a gap in the knowledge base appropriate searches took place on key topic areas such as vulnerable groups. Feedback from the working group also suggested topics to review. The current nature of the economic downturn made it necessary to monitor the news and newspapers and to locate original key sources of relevant news items.

**Working Group Membership**

PCT reps:
- Halton & St Helens - Sharon McAteer (chair - NHS Project Lead)
- Sefton - Pat Nicholl
- Knowsley - Richard Holford
- Wirral - Will Sopwith
- Liverpool - John Lucy (Associate Director of Public Health, Liverpool Primary Care Trust)
- Rachael Gosling (Liverpool Community Health NHS Trust)

Specialist support:
- Jude Stansfield: Mental Health Programme lead, ChaMPs
- Claire Maguire, Employment & Skills Manager with Sefton Council

LPHO:
- Alex Scott-Samuel (University of Liverpool Academic Supervisor)
- Lyn Winters (Liverpool Public Health Observatory Lead/ Researcher)

**What is health impact assessment?**

Health Impact Assessment (HIA) can be explained as “the estimation of the effects of a specified action on the health of a defined population.”¹ Health should be viewed holistically as much more than the absence of disease, but a “complete state of physical, mental and social well-being.”²

The definition of health used in the HIA is derived from the work of Lalondé³ and Labonté⁴ based on a socio-economic model of health and these key influences/determinants of health can be illustrated as layers of influence, as in Figure 1. The socio-economic model emphasises the interconnectedness between the layers. At the core are generally fixed determinants such as age, sex and genetic characteristics that
can have an effect on an individual’s health potential. The inner layer contains the lifestyle factors that can promote or damage health. According to this model the outer layers have the most influence on health. Individuals do not live in a vacuum, but interact with others in their immediate environment. Social interaction and support can have a protective influence on health even in unfavourable circumstances.

The wider influence of their living and working environment will also determine how effective their social and community influences are. The wider socio-economic, cultural and environmental conditions influence how people behave; determine attitudes, general access to healthy choices and a cohesive social environment. Thus the Dahlgren and Whitehead’s model is a useful reminder of the importance of wider factors for health.5

Figure 1: The main determinants of health

![Diagram of the main determinants of health](source: Whitehead & Dahlgren, 1991)

From these health determinants, it can be seen that the potential to improve the population’s health will come through social, economic and environmental reforms rather than through medical advances.7 Specific actions that grow out of public policy, can affect these determinants so they influence health either positively or negatively.8 9

Is this economic downturn different from previous recessions?
The way in which the recession\(^1\) impacts on the population’s health depends on a number of factors. This includes the extent, nature and duration of the economic downturn, the co-existent economic and social policies, the dominant socio-cultural values, the level of formal and informal welfare and the demographic changes in the labour market.\(^{10}\)

The UK economy officially entered into recession in the second quarter of 2008/09 (June 2008), which was confirmed in January 2009 by the definitive occurrence of two consecutive quarters of economic contraction. Although the economy is now officially in recovery, the effect of the recession may be prolonged.\(^{11}\) Indeed, Britain could face many more years of severe austerity to balance the country’s finances.\(^{12}\) A study by the Institute for Fiscal Studies\(^{13}\) claims that UK household incomes were relatively insulated from the immediate impacts due largely to the stabilising role of the state welfare system. During the financial year 2010-11, earnings, state benefits and tax credits all fell in real terms. It is estimated that this has led to a fall in median net household income of 3.5% the largest single-year drop since 1981, returning to its 2003-04 level. Furthermore, the decline in average living standards looks set to continue until at least 2013-14, but after the sluggish economic forecast by the Office for Budget Responsibility (OBR) this may be for many years longer.\(^{13}^{14}\)

The impact that a recession can have is complex, and can affect individuals and households in many different ways. The Audit Commission has developed a model to describe the stages of a significant recession and recovery:

**Wave 1: economic** – A relatively short period where economic output declines; firms fail or reduce staff numbers; unemployment rises quickly; and real incomes fall.

**Wave 2: Social** – A longer period in which output growth returns, but job losses continue. Unemployment remains high, bringing with it increasing housing, health and domestic problems.

**Wave 3: Unequal recovery** – Recovery occurs when the economy is expanding and unemployment has passed its peak. Investment and economic development return, but not all areas benefit. Some continue to decline, while others bounce back.\(^{15}\)

Many studies have looked at the impact of previous recessions to predict the likely impact on health of the current economic downturn. However, it has been noted that there are four key differences now to previous economic recessions:\(^{16}\)

**A diminished safety net for the unemployed.** Access and entitlement to out of work cash benefits and welfare services have decreased considerably and are more stigmatised. Therefore the extent to which the welfare system can act as a buffer against the negative social and health consequences of the economic recession has diminished.

**New unemployment co-exists with significant structural worklessness** in the form of long-term sickness absence and disability pension receipt.

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\(^{1}\) Period of general economic decline, defined usually as a contraction in the GDP for six months (two consecutive quarters) or longer. Marked by high unemployment, stagnant wages and fall in retail sales.
The nature of work has changed within Britain, during the last twenty years. A decrease in industrial employment and an increase in the size of the service sector have been accompanied by an increase in shift work and flexible, precarious, employment with increasing numbers of people working on either temporary contracts or no contracts, with limited or no employment or welfare rights. These new economic forms will also impact on the experience and distribution of unemployment as those with the least protection will be at most risk of unemployment, often without redundancy packages, such as women, the young and immigrants. Furthermore, a daily existence of low paid, high-strain, temporary employment, will make them ill prepared and least resilient to the additional negative health impact of unemployment.

Labour market is becoming increasingly feminised and gender roles are shifting. There seems little doubt that women have made huge progress; in numerically dominating areas of the labour market and entering and succeeding in previously male dominated occupations and professional groups. Therefore, the negative effects of unemployment may be more equally experienced by both genders.

**What are the mechanisms causing health impacts?**

Evidence from a recent literature review suggests that through the economic downturn there are three main intervening mechanisms causing health impacts: stress, frustration-aggression and ‘effect budgeting’.

The stress mechanism – declining economies increase the incidence of stressful job and financial events and increase the anticipation of stressful experiences such as job loss and financial difficulties. In turn these can increase the likelihood of experiencing other stresses such as marital difficulties. The stress mechanism assumes that most of the stress of everyday life comes from working therefore a reduction in time at work may reduce the prevalence of stress-induced illness. Figure 2 illustrates the links between socioeconomic stress, resulting from material deprivation and poor mental health.
Frustration- aggression - is based on the much-tested argument that individuals denied an expected reward may experience psychosomatic antecedents of aggression. Some exhibit antisocial behaviours whilst others cope by using alcohol or drugs. Thus contracting economies can increase the perception of unfair loss of earned rewards, and increase the incidence of intrafamily and workplace violence as well as substance abuse. However, it could have an inhibiting effect on violence and substance misuse, as workers who fear job loss will do whatever they can to avoid it.

‘Effect budgeting’ – this mechanism assumes that people have limited time, energy and money to manage their environment and experiences. A declining economy not only reduces the money available to many households, but also forces them to invest time and effort in managing the sequelae of lost jobs or lost income. These new allocations mean taking time, energy and money away from other investments these could include: exercise, socially supportive behaviour, good nutrition etc. This has also been described as “time poverty.”

What impact does a downturn have on health resilience of individuals and communities?

The economic downturn will impact in different ways upon businesses, individuals and communities, in that some will be more resilient or vulnerable than others to shocks in the external environment. Resilience has been defined as ‘the concept of mechanisms that protect people against the psychological risks associated with adversity’ that has four main processes: reduction of risk impact, reduction of negative chain reactions, establishment and maintenance of self-esteem and self-efficacy, and opening up of
opportunities. It is important that these mechanisms operate at key turning points in people’s lives such as major changes to circumstances that can be brought about by an economic downturn such as unemployment or risk of redundancy.\textsuperscript{19}

**Economic resilience**

Findings from a study looking into how people in the UK are coping with poverty during the aftermath of the current recession, shows that in the face of global economic shocks whilst coping with the rising cost of living, resilience is not a bottomless resource that can be freely replenished without cost in the form of increased pressures on time, high levels of stress and making sacrifices. Non-state actors were not a simple solution to protecting people against the downturn. Protection provided through non-state actors tends to be uneven and mediated through community gatekeepers, so that some people may be excluded.\textsuperscript{18}

Research by Experian Public Sector on economic resilience takes a holistic view of local areas and ranks them in terms of their ability to respond to economic shocks such as public sector cuts. Each area is given an overall rank from 1-324 where 1 is the best and 324 is the worst. The economic resilience assessment takes into consideration over 30 factors that include four themes: business, community, people and place. A clear north-south divide is apparent from the research.\textsuperscript{20} All Merseyside LAs and Halton have very low resilience and are ranked in the third in the country.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Overall rank</th>
<th>Business</th>
<th>People</th>
<th>Community</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>283</td>
<td>267</td>
<td>281</td>
<td>315</td>
<td>206</td>
</tr>
<tr>
<td>Knowsley</td>
<td>285</td>
<td>257</td>
<td>305</td>
<td>308</td>
<td>238</td>
</tr>
<tr>
<td>Liverpool</td>
<td>287</td>
<td>281</td>
<td>268</td>
<td>323</td>
<td>214</td>
</tr>
<tr>
<td>Sefton</td>
<td>274</td>
<td>293</td>
<td>230</td>
<td>290</td>
<td>113</td>
</tr>
<tr>
<td>St Helens</td>
<td>299</td>
<td>310</td>
<td>282</td>
<td>301</td>
<td>179</td>
</tr>
<tr>
<td>Wirral</td>
<td>288</td>
<td>314</td>
<td>144</td>
<td>307</td>
<td>172</td>
</tr>
</tbody>
</table>

*Source: Experian 2010\textsuperscript{20}\textsuperscript{21}*

*Business has been weighted 50% to reflect importance to short-term resilience. The other themes are each weighted 17%.*

Examples of what is included in different themes:

**Business:** vulnerable jobs, resilient jobs, business, start-ups, % self employed, solvency

**People:** Professionals, low skilled workers, household earnings, working age population, social cohesion, qualifications.

**Community** Claimant count, vulnerable to long term unemployment, vulnerable to declines in disposable income, social cohesion, life expectancy.

**Place** House price, school achievement, crime, green space.

Wirral has low business resilience but average earnings but it will be vulnerable to a drop in income as a result.\textsuperscript{29}

Liverpool performs very poorly in terms of ‘community resilience’. The local authority has the highest concentration of deprived localities of any local authority in England. In
addition, claimant count rates are incredibly high and a large proportion of households are vulnerable to long term unemployment. Perceived rates of social cohesion are low, and life expectancy averages for both sexes are amongst the lowest in the country.20

Liverpool also has the highest percentage of workless households in the UK at 31.9% where no adult aged 16 to 64 is in work. This is from ONS data derived from the quarterly Labour Force Survey, in which 53,000 households across the UK, containing more than 100,000 adults, are quizzed about their work or lack of it. Over the seven years since 2004 that data are available, Liverpool has had the highest percentage of workless households in five of the years, with it being in the top three in the other two years. Being sick or disabled (at 28%) was the main reason why members of workless households nationally are not in work, and this was also the percentage in Liverpool.22

In both the 1990/91 and 2008/09 recessions unemployment increased the most in the communities with high proportions of manufacturing workers and rented homes, and which already had highest unemployment. Many of these high unemployment areas have remained disadvantaged through economic boom and bust periods and have seen the greatest rise in unemployment since 2008-9.23 However, those communities with large proportions of people employed by the public sector and dependent on state benefits are now at risk. During the past year (June 2010-June 2011), 240,000 jobs in the public sector were lost. This figure includes 111,000 public sector job losses between March and June 2011, that are only compensated for by 41,000 jobs in the private sector during the same time period.24 25 This is the largest fall in public sector employment since comparable records began in 1999 and public sector job losses are proportionally higher in the poorest areas of the country.25 Liverpool Primary Urban Area (PUA)2 is in the top four cities projected to suffer the highest public sector job losses. Birkenhead PUA3 and Liverpool PUA have the highest welfare bill of all PUAs in England.26

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2 Liverpool PUA is defined by Centre for Cities as an aggregate of Knowsley, Liverpool and St Helens local authorities
3 Birkenhead PUA is defined as Wirral local authority
Table 2: Public and private sector employment, by local authority, Jan-Dec 2010

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Public Sector Employees as a Share of Total Employees</th>
<th>Public Sector Employee Density</th>
<th>Public Sector Employment Rate</th>
<th>Private Sector Employee Density</th>
<th>Private Sector Employment Rate</th>
<th>Significance test of difference from UK average (95% confidence level)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>Public Sector Employment Rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Above UK Average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Below UK Average</td>
</tr>
<tr>
<td>Halton</td>
<td>18.1</td>
<td>12.0</td>
<td>15.9</td>
<td>54.1</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Knowsley</td>
<td>26.7</td>
<td>15.1</td>
<td>17.9</td>
<td>41.6</td>
<td>42.7</td>
<td>✓</td>
</tr>
<tr>
<td>Liverpool</td>
<td>29.9</td>
<td>21.5</td>
<td>18.1</td>
<td>50.4</td>
<td>41.4</td>
<td>✓</td>
</tr>
<tr>
<td>St. Helens</td>
<td>22.8</td>
<td>11.8</td>
<td>20.0</td>
<td>39.8</td>
<td>47.5</td>
<td>✓</td>
</tr>
<tr>
<td>Sefton</td>
<td>32.3</td>
<td>17.3</td>
<td>23.5</td>
<td>36.2</td>
<td>46.6</td>
<td>✓</td>
</tr>
<tr>
<td>Wirral</td>
<td>29.5</td>
<td>14.4</td>
<td>19.5</td>
<td>34.3</td>
<td>45.7</td>
<td>✓</td>
</tr>
<tr>
<td>Liverpool City Region LEP</td>
<td>28.1</td>
<td>16.7</td>
<td>19.4</td>
<td>42.8</td>
<td>44.8</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: ONS

1 Public Sector Employee jobs located in the area as a share of total employee jobs located in the area.
2 Public Sector Employee jobs located in the area divided by the area’s population of 16 to 64 year olds.
3 Share of 16 to 64 year old residents of the area who report that they are employed in the public sector.
4 Private Sector Employee jobs located in the area divided by the area’s population 16 to 64 year olds.
5 Share of 16 to 64 year old residents of the area who report that they are employed in the private sector.

For LAs in Merseyside Sefton has the highest rate of public sector employment. At 23.5% the public sector employment rate is significantly higher than the UK average, while at 46.6% the private sector employment rate is significantly below the UK average.

How does the health impact of a downturn interact with the underlying social support arrangements?

A key determinant of health is having positive and supportive relationships with others. Social support, social networks and social cohesion can make people more resilient to an economic crisis. From evidence of previous recessions, the adverse health effects of rapid economic change were reduced substantially where many people were members of social organisations such as trade unions, religious groups or sports clubs illustrating the protective effects of social support. In times of economic crisis informal social welfare can provide people a place to turn to for support whether to borrow money, or to supply food or shelter or to get advice on sources of help. During the 1990s East Asian economic crisis Thailand and Indonesia experienced short term increases in death rates, but there was no obvious change in Malaysia. Health in Malaysia did not suffer at this time as there were no reductions in social protection.
Nevertheless, community cohesion is tested in times of scarcity with different groups fighting for access to scarcer resources, and with the ascendency of far right political groups who are quick to blame immigrants for the ‘victimhood’ of White British. Conflict is an issue that along with government, local community organisations must prepare for.5

Are vulnerable groups less resilient to this economic downturn?

Certain population groups are normally at a disadvantage, but during an economic downturn their health can be further compromised as their physical, mental and financial resources are least resilient to withstand the economic shocks. These groups include those with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.31 They will suffer from an unequal recovery from the economic downturn which will in turn increase inequalities in health and so the cycle of poor health will continue.32 At risk to cuts in public spending are services that promote long-term health and well-being (such as: adult social care, libraries, community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly.5 However, a court ruling has claimed that decisions in two LAs to axe library services are unlawful, as they have failed to take account of their equality duties. These councils should have assessed the disproportionate health impact the closures would have on vulnerable groups.33 Evidence from previous economic recessions shows that those with disabilities, ethnic minorities and low skilled workers will experience an increase in and longer duration of unemployment.34 During this economic downturn young people are also experiencing disproportionately high unemployment. The economic crisis is probably increasing the social exclusion of vulnerable groups as they may have to sacrifice social activities.35

How are people living in poverty and on low incomes affected?

A substantial amount of evidence has shown an association between socioeconomic status and mental health problems. In short, poverty is both a determinant and a consequence of mental health problems.36

Homelessness and housing problems

What the above mentioned vulnerable groups tend to have in common is a low income. It is expected that at the very least the economic crisis will bring more poverty, more foreclosures on houses, more homelessness and related housing problems.31

The UK Government homeless statistics for the quarter April to June 2011 showed local authorities had accepted 11,820 applicants categorised as homeless - a 17% increase from the same period in 2010.37 Charities have raised concern that the situation could get worse with soaring household and utility bills, unemployment and stagnant wages.38 Through housing market pressures, cuts in housing benefit and housing budgets alongside reforms in the Welfare Reform and the Localism Bills, it is feared the cumulative effects will almost certainly cause homelessness to increase further.39 The charity Shelter predicts that in Britain 35,000 (which is 630 people a day) will be faced with losing their home by the end 2011. Furthermore, from their own research 61% of people who have experience homelessness or the threat of homelessness said that it
directly led to a stress related illness, while 70% said they spent most of their time worrying about it.40

**How do people living in poverty cope with this financial crisis?**

A study for the Joseph Rowntree Foundation (JRF) looked at how people living in poverty in three different areas of the UK in 2009-2010 coped with the financial crisis, at the start of the recovery before cuts to welfare spending.18

- Changes to work patterns included job losses, having to travel further for employment, working more flexible hours and feeling less secure about current employment.
- Changes to everyday life included adapting to the rising cost of living which creates a considerable stressful burden by economising on food, heating and travel, spending more time and effort on shopping and cooking, having less nutritious food.
- Family, friends and local communities provided vital support and contributed to maintaining social cohesion. Informal financial systems, such as credit unions in Northern Ireland and loan committees in the Pakistani community in Oldham, were seen as valuable sources of support for residents and small businesses.
- State support protected people from destitution, with sharp rises in the numbers receiving out-of-work benefits. People singled out tax credits as vital protection for those in low-paid, insecure jobs.

Nevertheless, for some in this study the recession has meant worse diets, colder homes and less physical mobility, as they have been unable to adjust their spending without harming their well-being, with potentially longer-term impacts on health.18 Yet the economic downturn and cuts in public sector spending could widen health inequalities between the rich and poor. Compared to those living in the richest areas, people living in poor neighbourhoods in Britain already face up to 7 fewer years in life expectancy and 17 fewer disability free years.41

**How does an economic downturn promote fuel poverty and how does this impact on health?**

The elderly, disabled, babies, children and adolescents are more likely to suffer from the effects of fuel poverty as the household lives in an inadequately heated home, in an effort to save money. A household is said to be fuel poor if it needs to spend more than 10 per cent of its income on fuel to maintain an adequate level of warmth - usually defined as 21 degrees for the main living area, and 18 degrees for other occupied rooms. Fuel poverty is a combination of factors including: household income, energy-efficiency of a home and the cost of fuel. A recent report by Department of Energy and Climate Change (DECC) estimates that 5.5 million people in the UK now face living in freezing conditions through self-rationing and disconnection – with tenants in the private rented sector among those at highest risk of fuel poverty. During 2004-2009 there has been an increase in the proportion of households suffering from fuel poverty in all regions. In the North West this increased from 7% to 22%.42 Statistics collected by DECC shows fuel poverty is increasing in all areas covered by this report, with
Liverpool having consistently higher rates than other areas, from nearly 16% of households in 2006 to over a quarter in 2009. [See section on Local Indicators]

Through the economic downturn as the cost of energy has increased more than incomes, many people are finding it is harder to pay high energy bills. The majority of households in fuel poverty are consistently in the lowest three income decile groups. From 2003-2009, the number of fuel poor households in these groups rose from 1.2 million to 3.4 million. During the same period the number of fuel poor households in income decile groups 4 to 10 increased from 0.05 million to 0.53 million. Although households in the lowest income decile historically make up the majority of the fuel poor, the proportion actually fell from 71 per cent in 2003, to 46 per cent in 2009 – another illustration of the pressure of rising energy costs, pushing more households with higher incomes into fuel poverty.  

Furthermore, since the start of the economic downturn CABs have seen a big increase in people coming for help because they can't afford to pay their gas and electricity bills. During 2010 they advised over 100,000 people on fuel debt problems.

It is sometimes difficult to disentangle the precise causal link between ill health and fuel poverty-related problems. Cutting back on heating to maintain manageable fuel bills leads to cold homes and damp and/or mould growth – key determinants of poor health. A proportion of the excess winter deaths, particularly those due to respiratory disease, can be attributed to cold indoor conditions. Cardiovascular disease may be more linked to cold external temperatures. However ‘cold stress’ may also play an important role. This occurs when shock of a cold morning might cause too much cardiovascular strain, particularly if leaving a cold dwelling. Thus the impact of cold stress is reduced if people live in a warm home. With indoor temperatures 16°C or below respiratory problems become more common, and causes some cardiovascular risk. Exposure to temperatures between 12°C and 9°C for more than 2 hours causes core body temperatures to drop, blood pressure to rise and increased risk of cardiovascular strain. Cold homes are also linked to exasperating existing health problems such as asthma, bronchitis and arthritis (that can lead to accidents through stiff joints) and causing mental ill-health. It also increases the likelihood of minor illnesses such as colds and flu.

A recent review has found that excess winter deaths are three times as high in coldest homes as in the warmest. It found that most excess winter deaths among people in this group are attributable to either cardiovascular diseases (40% of deaths) or respiratory diseases (33%). Furthermore, children living in cold homes are more than twice as likely to have respiratory problems as children living in warm homes, the report found. A quarter of adolescents living in cold housing have mental health problems. This is five times the proportion among adolescents who have always lived in warm homes (1 in 20). The report says that improving the energy efficiency of the country’s housing stock is an essential step in reducing the number of households in fuel poverty.

**How is the economic downturn putting older people’s health and care at risk?**

Research published by PricewaterhouseCoopers suggests that many people with private pensions will be as much as 30% worse off compared with those with similar
savings who finished work in 2008, because of a combination of tumbling stock markets and interest rates at a record low. Furthermore, the Bank of England is resuming its quantitative easing programme, injecting £75 billion of new money into the economy making it harder to fund retirement schemes.\textsuperscript{46} Pension values and benefits are also reduced as they now only increase with the cost-of-living in line with the Consumer Price Index (CPI) that does not take into account the cost of housing (such as insurance), council tax, vehicle excise duty, and TV licences, all costs that consumers have to bear. Thus the CPI rises more slowly than the Retail Price Index (RPI) which it replaced in April 2011. People will also have to work longer before they can claim a pension and with the exception of Merseyside LAs people living in other areas of the country will have to wait until they are 65 before they can have a free travel pass. For those in their own homes, the combination of the house-price slump, the reduction in pension values, the loss of interest on savings, in addition to the rising cost of utilities bills means that many older people have reduced household budgets.\textsuperscript{5} They will therefore be at risk of fuel poverty and poor diet, with all the associated health impacts and may be isolated from others without free travel on public transport.

There is a crisis in care home funding for vulnerable older people, as councils are facing huge budget cuts, fees that have been paid by local authorities to care homes have fallen by 4\% in the past two years.\textsuperscript{47} Indeed one local council’s cuts in payments have been ruled as illegal in a landmark High Court case, as they failed to engage in any meaningful negotiation with care providers. Private care home managers have complained that the dwindling rates from councils fail to cover the cost of good quality services, and does not cover the costs of simply meeting the Care Quality Commission’s essential standards of quality and safety for care homes in England.\textsuperscript{47,48} Many providers may be forced to restrict places for publicly-funded residents, threatening the choice and amenities available for them. Others may close homes or choose only to operate in areas with high levels of self-funding residents.\textsuperscript{47}

**Are there specific impacts on the health of children and young people?**

Among people losing their jobs, the psychological impact will appear in the short term but economic pressure will also affect families and constitute a risk factor for the longer-term mental health of children. Thus if preventive actions are not in place, there is a risk that the toll of the crisis will be paid by the next generation – who are now children.\textsuperscript{49}

Efficiency savings in schools could affect the role of teaching assistance that can adversely impact on classroom behaviour and exam results. There will be a disproportionate effect on children from disadvantaged backgrounds not being able to access higher education.\textsuperscript{5} If a new single national formula is introduced in 2013, using data from the Department of Education, the IFS claims that primary and secondary schools in some of the most deprived areas such as Liverpool could lose out from the changes with funding being cut by more than 6\% for primary and more than 10\% for secondary schools. Furthermore, the government would be implementing this reform alongside cuts to the overall schools budget, limiting its ability to compensate the losers or ease the transition to the new system.\textsuperscript{50}

Adverse effects of the recession can put a strain on family relationships. Further cuts in social services will put even more pressure on children’s services that could result in
more failures unless collaborative working is improved.\textsuperscript{5} With LA cuts to Sure Start centres there is real fear that they are being diluted to such an extent that advances in tackling child poverty in this country will be dramatically reversed.\textsuperscript{41} The 2010 Child Poverty Act commits successive governments to cut absolute child poverty by 2020 to 5% and relative poverty by 10%. However, a study conducted by the Institute for Fiscal Studies (IFS) claims that these targets will be missed by a wide margin, as absolute and relative child poverty are forecast to be 23% and 24% in 2020-21 respectively. Universal Credit should reduce poverty substantially, but the poverty-increasing effect of other government changes to personal taxes and state benefits will more than offset this.\textsuperscript{52} Individuals are in absolute poverty if household income is below 60% of median household income held constant at the 2010/2011 level. Relative poverty is when an individual is living in a household whose income is below 60% of the median household income.\textsuperscript{53} The Government targets are tracked using figures before housing costs, which show a lower rate of poverty because the costs of housing are so high. Without taking housing costs into consideration IFS projections claim 2.5 million children (21.3%) in the UK are now in relative poverty but after housing costs a further 1 million are.\textsuperscript{52} The reality is that with an income of less than 60% of the median, families struggle to meet basic needs like food, heating, transport, clothing and the extra costs of schooling like equipment and trips. Parents will often try and shield their children from some of the impacts of financial hardship and the stigma of ‘poverty’ by such measures as skipping meals.\textsuperscript{54}

Analysis of the Family Resources Survey by The Children’s Society finds that 40% of disabled children (320,000) live in relative poverty, once the additional costs of their disability is accounted for with 110,000 of these children living in severe poverty (in households on less than 40% of median income). Where a disabled child is in a household with a disabled adult the poverty figure rises to 49%. The Children’s Society is concerned that after Universal Credit is introduced in 2013 around 100,000 disabled children will lose up to £27 per week.

The Children’s Society’s own research reveals that a decrease in family income directly relates to low well-being. Children in households where income has fallen are likely to be twice as unhappy as those in homes where income has risen. They are at greater risk of suffering from mental health issues and behavioural problems and may also be at risk of performing badly at school.\textsuperscript{55-57} The effects of extreme poverty on children include deficits in cognitive, emotional and physical development, and the consequences on health and well-being are lifelong.

The Child Poverty Act requires local authorities to produce child poverty strategies and work with local partners on reducing and preventing child poverty in their area. This is particularly difficult for local authorities with the highest rates of child poverty. Yet the spending settlements that have been provided by central government for 2011-12 and 2012-13 tend to be less favourable for these local authorities. Mid-year estimates for 2010 puts Liverpool Local Authority within the top 20 LAs with highest levels of child poverty across England (35% of children in poverty) and Liverpool Riverside within the top 10 parliamentary constituencies with the highest levels of child poverty with 48% of children living in poverty.\textsuperscript{54}
During July-September 2011, ONS figures showed that 1.02 million 16-24 year olds were out of work. That is 1 in 5 young people.\textsuperscript{58} Young people are particularly badly hit by unemployment and can suffer from the long-term ‘scarring’ that can occur after such a bad early experience with the labour market. Research on previous recessions shows this can have a lasting adverse effect on the employment prospects of low-skilled young people aged 16-18. Their early experience of unemployment can have a substantial wage ‘scar’ of low wages up to the age of 23 and a modest residual wage scar for up to 20 years even if employment was secured. If they are employed they are more likely to be on temporary contracts that are the first to be cut when employers wish to reduce costs.\textsuperscript{59}

For young people not in employment, education or training (NEET) there is particular concern. In England around 16\% of 16-24 year olds are NEET. For some this can lead to long term difficulties in the labour market with reductions in wages and higher chances of future unemployment. Indeed, people with low skills have greater difficulty in finding work in an economic downturn.\textsuperscript{34} Public sector cuts are restricting youth services and the capacity of government to help people to enter the labour market.\textsuperscript{60} Young unemployed have a higher risk of getting mental health problems, such as depression, than young people who remain employed.\textsuperscript{35, 61} In a UK survey of young NEETs 25\% said being unemployed caused arguments with their family and more than 1 in 10 said unemployment drove them to drugs or alcohol.\textsuperscript{62} Attempted suicides are up to 25 times more likely for unemployed young men than for those in jobs.\textsuperscript{63}

The coalition government’s new job fund of £1bn to be spent over three years will provide job subsidies and the expansion of apprenticeships and of the work experience placements in the private sector for young people who are unemployed. However, the package has been criticised by the Labour party for being funded from cuts in working family tax credits. The work-experience programme has also been criticised by the TUC as there have been wide-spread reports of exploitation of the young people, whilst they have been ‘edging out other workers who should be paid the going rate for the job’.\textsuperscript{64}

**How are austerity measures affecting key determinates of health for disabled people?**

Disabled people suffer disproportionately from low incomes (from unemployment, unstable and low paid employment) and higher costs. When a conservative estimate of the additional costs of disability is taken into account it is estimated that 47.4\% of families with a disabled member are living below the poverty line.\textsuperscript{65} Other studies suggest that the impact of the costs of disability put the percentage of disabled people living in poverty to over 50\%\textsuperscript{66} or almost 60\%.\textsuperscript{67} As far more disabled people live in poverty than the rest of the population they are therefore particularly vulnerable to cuts in service provision and welfare benefits.\textsuperscript{68} They have no “financial resilience” to absorb or recover from financial shocks.

As part of the government’s deficit reduction strategy it is proposing that a Personal Independent Payment (PIP) will replace Disability Living Allowance (DLA) for those eligible for work between the ages of 16-64. These DLA claimants will be reassessed to measure the functional impact of their disability from April 2013 to see whether they are entitled to the new PIP.\textsuperscript{69} However, it has been pointed out that two people with a
similar disability could have different disability-related costs if one is financially secure, has a good social network, and suitably adapted home and transport and the other is unemployed, isolated in unsuitable rented accommodation and dependent on public transport. As several benefits, including Housing Benefit, Employment Support Allowance and others are set to be cut, so disabled people are likely to see a significant decrease in their income.

Ministers are looking to prune £350m from the civil legal aid budget by 2014-5 as part of cuts across government to reduce its deficit. The disability rights groups say the changes mean up to 80,000 people will no longer be able to get access to publicly funded legal advice to help them challenge benefit decisions. Campaigners say those affected will not be able to find legal help elsewhere and it could have a "serious impact" on their finances and peace of mind - making it harder for them to return to work in the future.

As a result of the financial crisis every local authority has had to implement cuts. A recent study by the think tank Demos has collected data from LAs and ranked them according to how well they are coping with deficits in their local budget and shielding disabled people from harm. In England, each local authority was assigned a score based on:

1. Changes to social care budgets for children, adults and older people between 2010/11 and 2011/12
2. Average changes in user charges for a range of disability services including transport, community meals, respite etc. between 2010/11 and 2011/12
3. The care contribution policy put in place – how the local authority takes disability related benefits into account when calculating the amount people have to contribute to their social care funding
4. The level of efficiency reduction placed on personal budgets (which can make personal budgets lower than the cash equivalent of the care people would receive directly from their council)
5. The current eligibility criteria for state funded social care in the local authority (low, moderate, substantial or critical needs)
6. Any changes in eligibility criteria between 2010/11 and 2011/12

The point scores from each of these areas were combined to give an overall score out of 100, and local authorities were ranked accordingly from 1-152 where the highest scoring LA is ranked 1 and the lowest is ranked 152.
Table 3: How well local authorities in Merseyside and Halton are protecting services for disabled people

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Children’s &amp; Families social care budget change (%)</th>
<th>Adult budget change (%)</th>
<th>Older people budget change (%)</th>
<th>Overall Budget Cuts (%)</th>
<th>Cut level</th>
<th>Local authority ranking (coping score)</th>
<th>Colour group / coping level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>-11.67</td>
<td>-1.92</td>
<td>23.49</td>
<td>3.14</td>
<td>Increase 1</td>
<td>1 - Very Good</td>
<td></td>
<td>Knowsley has said that there have been no closures of disability care or support services in the local area, nor have they increased any charges for these services.</td>
</tr>
<tr>
<td>Sefton</td>
<td>-10.15</td>
<td>-5.01</td>
<td>-5.94</td>
<td>-7.28</td>
<td>High cut 15</td>
<td>2 - Good</td>
<td></td>
<td>Sefton has increased the cost of day centre activities to £30 per day and the cost of using accessible transport in the local area by £5 per journey for those who use their own money to pay for the service.</td>
</tr>
<tr>
<td>Liverpool</td>
<td>-4.65</td>
<td>-19.05</td>
<td>10.79</td>
<td>-4.04</td>
<td>Medium Cut 23</td>
<td>2 - Good</td>
<td></td>
<td>Liverpool has increased the cost of care in the home by 3.7%, day care centre and disability equipment costs have increased by 4%.</td>
</tr>
<tr>
<td>St Helens</td>
<td>-9.44</td>
<td>-5.76</td>
<td>-7.28</td>
<td>-7.75</td>
<td>High cut 54</td>
<td>3 - Well</td>
<td></td>
<td>St Helens has increased the cost of using specialist transport by 42% and the council also takes into account all of a disabled person’s Disability Living Allowance (DLA) when assessing how much they will contribute towards a disabled person’s care. Disability Living Allowance is a benefit, which is designed to help disabled people meet the extra costs of living with a disability. Finally, the council has kept the eligibility for care and support at the lower level of ‘moderate’ needs and above.</td>
</tr>
<tr>
<td>Halton</td>
<td>-29.53</td>
<td>18.99</td>
<td>-22.36</td>
<td>-11.71</td>
<td>Very High Cut 75</td>
<td>4 - OK</td>
<td></td>
<td>Halton has increased the cost for using local day care centres, community meals services, specialist transport, short breaks or respite service and emergency alarms by 2%. The council has closed one small children’s home and moved the children over who used the service during the day to a different day service.</td>
</tr>
<tr>
<td>Wirral</td>
<td>-14.12</td>
<td>-23.09</td>
<td>-31.67</td>
<td>-21.67</td>
<td>Very High Cut 96</td>
<td>5 - Poor</td>
<td></td>
<td>Wirral has recently closed 5 local respite services and intermediate care homes as part of a project to outsource its care to an independent organisation. It has also introduced a new charge of £4 a week for people who use local telecare services that use technology to enable the disabled person to live independently. The council currently takes into account 75% of a person’s income when working out how much they will contribute towards the cost of their care. They are considering whether this should be increased to 100% of a disabled person’s income.</td>
</tr>
</tbody>
</table>

Source: Demos68
Knowsley is the best LA in England in terms of provision and access to welfare services for disabled people, despite being the eighth most deprived area in the country.68 Knowsley has an integrated health and social care system where there are joint appointments at senior level. This allows the two bodies to pool budgets, establish integrated teams and merge functions. Recently the partnership expanded further to bring in leisure and cultural services, to become Knowsley Health and Wellbeing. By combining services together and joint commissioning it has been able to protect its disabled population from the worst of the cuts and has given the authority an opportunity to make cost savings.68

However, across the country there is huge variation in front-line eligibility, user charges and financial rules even within neighbouring areas. What level of support a disabled person is entitled to can have life changing implications. Disabled people use multiple services and supports in their communities. Therefore a strategy to evenly spread the cuts of a number of services will often converge on disabled families leading to a cumulative and disproportionate impact. One of the most striking findings of Demos’ study is that most local authorities do not systematically collect data that enable them to predict how budget cuts will affect disabled people living in their area.68

Are women and single mothers disproportionately affected by the austerity measures?

According to a report by the Fawcett Society through the government’s austerity measures women are losing their financial security and their human rights are under attack.72 They are suffering from cuts to their jobs, benefits and services that support women’s everyday lives. The measures are undermining women’s hard won rights to protection from violence and access to justice, as the Ministry of Justice plans to save £350m a year from the legal aid budget. A letter in the Guardian from women’s groups is calling on the justice secretary to review proposed changes to legal aid which will restrict access for those who have suffered domestic violence.73 Furthermore, there is a growing likelihood that women will be the ones left ‘filling the gaps’ as state services are withdrawn. It is those who have the least to lose that will lose the most: women who are unemployed or on low incomes, pregnant women, families, single mothers and pensioners, victims of sexual, domestic or other violence. Signatories to the Fawcett Society report include many charities and organisations that support women including: Eaves Housing for Women, the End Violence against Women coalition, Rape Crisis, Child poverty Action Group, Unison, Daycare Trust, Gingerbread and Maternity Action.72

Recent research conducted by the Centre for Human Rights in Practice, at the University of Warwick also endorses these finding.74 It concludes that many of the spending cuts will have a disproportionate impact on women and will lead to greater inequality between women and men. The combination of cuts may have a negative impact on some women’s human rights.74 Nearly a third (30% of women) but only 15% of men rely on state support for at least 75% of their income.75 The TUC has estimated that 65% of people who lose their jobs as a result of public sector pay cuts will be women.76
Research from The Fawcett Society and the Institute for Fiscal Studies have found that single women and single mothers are set to lose from benefit changes. After taking into consideration all tax and benefit reforms to be introduced between 2010 - 2015, single women will lose more as a proportion of their income than other households as a result of the cuts. Single mothers can expect to lose 8.5% of their net annual income by 2015 - more than a month's income each year. The government has announced that £300m would be made available for childcare, but analysis for the Resolution Foundation found the change would only benefit those working less than 16 hours per week.

Research from the National debt charity Consumer Credit Counselling Service (CCCS) shows that over half (53.7%) of their clients, in the first six months of 2011, who have been in mortgage arrears are single women between the ages of 40-59. Two thirds of those are also on low incomes between £10,000 and £20,000 a year. During May-July 2011, women’s unemployment has increased by 41,000 (more than men's) to 1.06 million the highest figure since April 1988.

The cumulative impacts of cuts: cuts to advice, housing and counselling services to women, cuts to the budget of the police, Crown Prosecution Service and National Health Service combined with cuts to Legal Aid and cuts to welfare benefits will all have an impact on the human rights of women victims and survivors of violence. For instance, cuts and other changes to welfare benefits risk increasing women’s financial dependency on men, making it harder for women to leave violent relationships.

Changes to funding for further and higher education may reduce women’s ability to access education and/or increase the long term costs of education to women. The indirect impact of cuts to school budgets may disproportionately impact on women who tend to be the primary carers of children.

Have ethnic minorities been disproportionately affected during this economic downturn?

The labour market situation of ethnic minority groups first began to deteriorate in the recessions of the 1970s and 1980s. Men and people from selected ethnic groups lose out because they tend to be concentrated in sectors of the economy where the long-run decline in employment has been accelerated by the recession. Also, spending cuts in the public sector may have a disproportionate effect on ethnic minority groups, because this is a sector where they are disproportionately employed.

Findings show that, as in previous recessions, ethnic minorities have been disproportionately affected by the rise in unemployment in this recession. Black, black British and mixed race young people have seen the biggest increases. Black or Black British people aged 16 to 24 years old have the highest rates of unemployment over 48%, an increase of nearly 12.8% since the start of the recession. Mixed ethnic groups have seen the biggest increases in unemployment, from 21% in March 2008 to over 35% in November 2009. Youth unemployment among white people has risen from 12.4% to 20.4%. At 5.9%, the lowest change
has been among Asian British young people – but overall unemployment in this group remains high at 31.2%. As in previous recessions in the 1980s and 1990s, minority unemployment may stay relatively high for a long time after an economic recovery.

Immigrants are likely to find work in precarious employment in the service sector working on either temporary contracts or no contracts, with limited or no employment or welfare rights and at a high risk of unemployment, often without redundancy packages. Furthermore, a daily existence of low paid, high-strain, temporary employment, will make them ill prepared and least resilient to the additional negative health impact of unemployment.

There appears to be an association between this rise in unemployment and increased use of specialist mental health services. The Mental Health Bulletin 2009/10 shows that whilst the number of people using specialist mental health services rose across all ethnic groups, for the mixed ethnic group there was a rise of 17.7%. There was a particularly noticeable rise in the proportion of inpatients who were detained from the black group, of whom 66.3% were detained in 2009/10 (compared with 53.8% in 2008/09). In 2009/10 Mixed and Black and Black British groups both have rates of access to services that are over 40% higher than for the majority White group (at approximately 3,800 per 100,000 population compared with about 2,700 for the White group).

What are the impacts on physical and mental health states?

Association between mortality and welfare spending cuts

Using evidence from 15 EU countries from 1980-2005 an association has been found between increased welfare spending and a decrease in mortality. Specifically the study found that an increase in spending of $100 on welfare (excluding healthcare spending) was associated with the following reductions in mortality: all cause mortality by 0.99%; cancer deaths by 0.065%; cardiovascular disease (CVD) by 1.23%; suicides by 0.62%; alcohol related deaths by 2.80% and tuberculosis by 4.34%. The $100 was based on purchasing power parity of the $ in 2000.

It is estimated that in the UK welfare spending will be cut by £18 billion in 2014-2015 and from projected population estimates this equates to £283.47 per capita cut in welfare spending. At current exchange rates $100 is equivalent to £61.86. Applying these figures to available local mortality data for 2008/9, table 4 shows estimates of the number of additional annual deaths across the Mersey PCT cluster which might be associated with the 2014/15 welfare cuts. Unfortunately, figures from this analysis were not available for Wirral.
Table 4: Estimated additional annual deaths across the Mersey PCT cluster associated with forthcoming 2014/15 UK welfare spending cuts*

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Knowsley</th>
<th>Liverpool</th>
<th>Sefton</th>
<th>St Helens</th>
<th>Halton</th>
<th>Mersey PCT cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Causes</td>
<td>63</td>
<td>195</td>
<td>139</td>
<td>83</td>
<td>51</td>
<td>531</td>
</tr>
<tr>
<td>Cancer</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>CVD</td>
<td>21</td>
<td>67</td>
<td>53</td>
<td>31</td>
<td>18</td>
<td>191</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Liverpool PCT

* Figures have been rounded to the nearest whole number

However, a caution is necessary in interpreting these figures, as the authors from the original research pointed out associations do not necessarily prove causality and the reverse of their findings thus reducing welfare spending by an equivalent amount will not necessarily cause excess mortality by the same ratio. “Nevertheless, the maintenance of social welfare programmes seems to be a key determinant of future population health that should be taken into account in ongoing economic debates.”

Cardiovascular disease

Emotional states associated with job loss, including anxiety and depression, may influence cardiovascular disease (CVD) through excessive activation of stress response pathways. The evidence suggests there will be deterioration in health for those who become long-term unemployed or who enter into a cycle of low paid insecure employment. Risk factor studies from America, that compare the health of individuals exposed or unexposed to contracting labour markets or to undesirable job or financial experiences, such as involuntary job loss, suggests that undesirable job and financial experiences will increase the risk of acute CVD, nonspecific morbidity, and mortality later in life. However, this is not supported from Northern European studies which may be explained by differences in the social and financial services available following job loss as well as by the relatively younger age of the cohorts studied in Northern Europe.

Morbidity

In terms of limiting long-term illness and self reported general health, studies indicate that these decline during economic recessions, at least in children under 18. Studies have consistently shown that unemployment, which increases in economic downturns, is linked to poorer health. The links between poorer health have been explained through the psychological effects of unemployment (e.g. stigma, isolation and loss of self-worth) and the material consequences of a reduced income. Along with poorer mental health there is a reported decline in self-reported health and limited long-term illness. In Greece which has suffered disproportionately from the economic crisis and has very high unemployment, there was a significant rise (14%) in the prevalence of people reporting that their health was bad or very bad, whilst there was a decline in the number of people eligible for sickness benefit of about 40% between 2007 and 2009.

However, there is some counter evidence which suggests that some chronic conditions and acute morbidity may actually decrease during economic recessions.
Mental health

The strongest negative effect of an economic downturn is on mental health. Mental health is not merely the absence of mental disorders or symptoms but also a resource supporting overall well-being and productivity. There is consistent evidence that the economic downturn may increase suicide and alcohol-related death rates, which can be seen as markers of deterioration of mental health. The majority of new disability claims are on the basis of mental health. Mental health can develop as co-morbidities among those initially out of the labour market through physical conditions. Table 5 summarises the economic downturns effects on mental health.

Table 5: Impact on determinants of mental health problems

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Mediated by</th>
<th>Health Impacts</th>
<th>Population most at risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rising unemployment</td>
<td>Financial strain; loss of: social status; identity; self-esteem, physical and mental activity</td>
<td>Psychological distress, alcohol abuse, depression and suicides</td>
<td>Young aged 15-24 Middle-aged &amp; unmarried men/single women</td>
</tr>
<tr>
<td>Job insecurity</td>
<td>Narrowing of options &amp; choices; loss of control; fear of job loss; financial difficulties; workload increase;</td>
<td>Common mental health problems; job stress</td>
<td>Low skilled; public sector workers and others in sectors having to reduce personnel</td>
</tr>
<tr>
<td>Households in high debt increase</td>
<td>Financial strain; worry Housing payment problems; consumer debt</td>
<td>Poorer mental health. Risk factor for mental disorder; increased occurrence of major depression</td>
<td>low income workers; those with little experience of coping with hardship; single, females/mothers</td>
</tr>
<tr>
<td>Increased poverty</td>
<td>Social exclusion; inequality</td>
<td>Mental health problems; depression and suicide; developmental deficit (emotional, cognitive, physical)</td>
<td>Poor or living near the poverty line; children growing up in extreme poverty: low educational levels</td>
</tr>
<tr>
<td>Adverse life style changes</td>
<td>Increased alcohol intake; binge drinking</td>
<td>Rise in suicide; alcohol related deaths</td>
<td>Lower educational group</td>
</tr>
<tr>
<td>Families under pressure</td>
<td>Strain on parental mental health; marital interaction</td>
<td>Poor mental health; feelings of helplessness; young – confusion, anger &amp; insecurity</td>
<td>Mothers, children &amp; adolescents</td>
</tr>
<tr>
<td>Cuts in health systems &amp; social protection</td>
<td>Loss of state support to mitigate against the impact of economic downturn</td>
<td>As above</td>
<td>As above; families</td>
</tr>
</tbody>
</table>

Source: Wahlbeck and Awolin
Is rising unemployment increasing mental health problems?

UK unemployment figures released for July-September 2011 showed the number of unemployed 16-24 year olds had risen to 1.02m, to reach 21.9% of the economically active population for that age group (up 1.7% on previous quarter). The unemployment rate for 16-24 year olds are the highest since directly comparable records began in 1992. The unemployment rate for the economically active population also rose to 8.3% (up 0.4% on previous quarter) and is the highest since 1996 and the number of unemployed in the UK (2.62m) is the highest since 1994. In the North West the unemployment rate for 16-64 year olds is 8.7% (down 0.3% from previous quarter). With economic growth remaining sluggish for some time to come the public sector is expected to shed 710,000 jobs by 2017. In combination with a weaker outlook for private sector job creation the Office for Budget Responsibility (OBR) now expects unemployment to peak at 2.8 million by the end of 2012, and this will put downward pressure on earnings growth across all sectors of the economy for several years to come.

In the UK unemployment is an important determinant of health as for the majority of people it is the main source of income. Unemployment is a lagged consequence of the recession. Even as growth returns it is predicted that unemployment will continue to rise and social problems worsen such as mental ill-health. Unemployment is the biggest trigger into poverty, and unemployed people are almost twice as likely as the population average to experience persistent poverty over a four-year period.

Those still in work but suffering from job insecurity may experience mental health effects that reduce productivity, through stress, anxiety and depression-related disorders. This will decrease productivity which is important for economic growth. Worries about job losses have made stress the most common cause of long-term sick leave in Britain with employers planning redundancies most likely to see a rise in staff mental health problems. Stress in the public sector is becoming a particular challenge through the sheer amount of major change and restructuring. At the same time there is a slowing in the jobs market. With the fear of being targeted for redundancy schemes over a quarter (28%) of employees are struggling into work when sick, according to a CIPD survey of nearly 2 million workers.

People suffering from financial strain will be particularly at risk of mental health problems. During 2009 the mental health charity Rethink, said its information centres and telephone advice lines were reporting a surge in people experiencing problems as a result of financial difficulties. These include people who have been ‘high fliers and now find life without their jobs overwhelming’.

Is the economic crisis causing rises in violence, suicides and homicides?

Rapidity of economic change appears to be a key hazard to health. The direction of change seems less important. Several studies have found that deaths increase when the economy is expanding or contracting. However, rises in
unemployment are associated with significant short-term increases in premature
deaths from intentional violence, while reducing traffic fatalities. Every 1% increase
in unemployment was associated with a 0.79% (95% confidence interval (CI) 0.16 to
1.42) rise in suicides for those less than 65 and a 0.79% (95% CI 0.06-1.52)
increase in homicides.92

It should be noted that suicide rates in England and Wales may be underestimated,
as since 2001 narrative verdicts are increasingly being used. A narrative verdict is a
factual record used to break down the circumstances under which a death occurred.
These verdicts do not attribute the cause to a named individual and are therefore
difficult to interpret by ONS with the result that many suicides could be recorded as
accidents even if suicide is strongly implied. This could lead to misleading
evaluation of national and local suicide prevention strategies and a masking of the
effects of the current economic crisis. The variation in practice by different coroners
means that local figures could be unreliable.101

In Greece during the current economic crisis, in adults, unemployment has risen
from 6·6% in May, 2008, to 16·6% in May, 2011 (youth unemployment rose from
18·6% to 40·1%). Suicides rose by 17% in 2009 from 2007 and unofficial 2010 data
quoted in parliament mention a 25% rise compared with 2009. The Minister of
Health reported a 40% rise in the first half of 2011 compared with the same period in
2010. A quarter of callers to the national suicide helpline faced financial difficulties in
2010 and reports in the media indicate that the inability to repay high levels of
personal debt might be a key factor in the increased suicides. Other alarming
indicators include the rise in violence and homicide and theft rates nearly doubled
between 2007 and 2009.90

There is no reliable evidence that the economic downturn will increase intimate
partner violence.102

How are health behaviours being affected by the economic downturn?

The extent to which economic changes impact on health depends on the extent to
which people are protected from harm from risk factors. For instance, during the
Great Depression in America that began during 1929 ten years after the introduction
of prohibition, alcohol was more difficult to obtain than in the past and during this
depression there were fewer deaths. Mortality rate in American cities actually fell
during the crash by about 10%. In contrast, after the collapse of the Soviet Union in
1991, accompanied by economic decline, there was a rapid increase in death rates
by up to 20%. A culture of heavy drinking was deeply ingrained in the USSR with
cheaply available alcohol at this time.29 In some studies unemployment is linked to a
higher incidence of risky health behaviours, in particular among young men including
problematic alcohol use and smoking.103

Alcohol misuse has health and social consequences borne by individuals, their
families, and the wider community. According to the latest findings from the North
West Public Health Observatory in their updated 2011 Local Alcohol Profiles for
England (LAPE), almost 900 more people are admitted to hospital each day for
drinking than five years ago. There were 1.1 million alcohol-related admissions in
England in 2009/10. This equates to 3,000 a day, compared to 2,100 a day in
2004/5. Furthermore, alcohol-related illness and injury rates are at their highest in Lancashire and Merseyside. Rates of hospital admission varies across England with 3,114 admissions for alcohol per 100,000 people in Liverpool, compared to 849 per 100,000 in the Isle of Wight.  

During this economic crisis in Greece the prevalence of heroin use reportedly rose by 20% in 2009, from 20,200 to 24,100. Budget cuts in 2009 and 2010 have resulted in the loss of a third of the country’s street-work programmes. There has been an increase in new infections of HIV which were expected to increase by 52% in 2011, with half due to intravenous drug use. However, there were some positives: a marked reduction in alcohol consumption and drink-driving.  

How does a downturn impact on diet and is this temporary or the catalyst of new habits?  

In western countries there is an association between economic downturns and worsening diets as people try to save money by using/relying/switching to cheap junk food. Agricultural subsidies promote production of high fat, energy-dense foods while healthier food such as fruit and vegetables receive little government support in the EU or US. Not surprisingly fast food restaurants have been increasing their profits and staff recruitment during the crisis. Ingredients such as trans-fatty acids, used in fast food, significantly increase CVD risk.  

The rising cost of living has already increased the strain of eating nutritiously and for some a struggle to provide food in adequate quantities. Thus coping with the economic downturn and rising cost of living will mean poverty is increasingly associated with obesity and other nutrition related conditions. For infants the impact of poor diet in the first two years of life is irreversible.  

Research by Fareshare, which redirects food trade surpluses to those in need through daily distributions to organisations such as homeless hostels, day centres, breakfast clubs and women’s refuges, has confirmed its donations were reaching 35,000 people a day, up from 29,000 a day last year. The organisation has seen the largest annual increase in the number of charities asking for handouts, as low-income families are struggling with rising food prices, and one in three charities it surveyed was facing government funding cuts. Indeed, 42% of charities reported an increase in demand for food in the past year as food prices soar and the recession bites, putting additional strain on families and people on low incomes. FareShare’s survey found that 54% of these charities’ clients have gone without food for a day or more at some point during the past year and 41% are unable to buy food on a regular basis, meaning that they are more reliant on these charities for help.  

Due to poverty, thousands more young people, who are unable to feed their family, are turning to food banks. The Trussell Trust, which runs the UK’s only national network of food banks, is seeing more 16 to 30-year-olds through its doors because of high youth unemployment brought on by the economic crisis. The numbers of people using its food banks had increased from 41,000 last year to almost 61,500 in the past 12 months.
As the Chancellor’s Autumn statement has announced that there will be no increases in child tax credit, the child poverty action group has commented that “Britain’s poorest families have been abandoned today and left to face the worst.”

Poor families tend to live in deprived neighbourhoods where opportunities for buying cheap fresh foods are scare. However, they may be helped if they are given access to ‘bag a bargain’ schemes that have been made available in some Sure Start children’s centres, where they can buy locally produced reasonably priced fruit and vegetables. Also, if the popular Knowsley ‘veggy van’ service (supported by Knowsley NHS) that provides fresh cheap fruit and vegetables to key locations and house deliveries was made more widely available and replicated in other areas. Targeted information and ideas on how to retain a balanced diet on a low budget have been provided in children’s centres and this is also an approach that might be extended to the wider community.

On a positive note, over a quarter of people surveyed by a marketing company in 2009 have said they are growing their own fruit and vegetables. Through a £3,000 NHS Health and Wellbeing grant an 8-week trial is being held so people who are registered with a GP in Southampton can be considered for a scheme that offers a gardening course in an effort to combat depression, anxiety and low moods.

Are there any positive impacts from the economic downturn?

There is something of a debate over the impact of a recession on health with some arguing that it is generally bad for health and those that propose that it can have positive effects brought about through increased opportunities for leisure time as job pressures and working hours reduce. How people deal with difficulties like unemployment in times of economic crisis depends on their coping mechanism. If struggling with an inadequate income opportunities for using leisure time will be limited. However, reductions in income can lead to a reduction in hazardous health behaviours and car accidents and traffic fatalities decrease. Indeed in Greece there has been a marked reduction in alcohol consumption and drink-driving. In an effort to combat high food prices 25% of a thousand UK people surveyed in 2009 said they have started growing their own fruit and vegetables, this can also have a beneficial impact on mental health.

The adverse effects of a recession is reduced where many people are members of social organisations such as trade unions, religious groups or sports clubs illustrating the protective effects of social support. In times of economic crisis informal social welfare can provide people with a place to turn to for support whether to borrow money, or to supply food or shelter or to get advice on sources of help. The crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient.

There is some evidence to suggest that some chronic conditions and acute morbidity may actually decrease during economic recessions.
What is the impact on public service demand?

Antidepressant use

Job loss (caused by plant closes in Austria where health insurance is mandatory for workers) for males showed a significant increase in spending on antidepressants and other psychotropic drugs as well as for hospitalisations related to mental health problems for men, although the effects are economically rather small; and sickness benefits strongly increase due to job loss. However, this sickness benefit increase is mainly due to sickness benefit rules rather than a deterioration in health status. The authors point out that this research is in line with the hypothesis that unemployment causes mental health problems whereas physical health appears to be largely unaffected. Certainly in the literature the physical effects of the recession are debatable. Nevertheless immediate health effects may not show up in physical health conditions but more likely in mental health.

During 2008 as the economic downturn started to take effect, in England there were 2.1m more prescriptions of antidepressants than in 2007, leading to concerns that doctors were increasingly supplying the drugs as a "quick fix" without attempting to address the underlying cause of the problems and perhaps use alternative therapies. In total, 36m prescriptions were given out, an increase of 24% over the previous five years. Furthermore, 22 of the 25 highest prescribing PCTs were in the north of England.

Figure 3: Map of anti-depressant prescriptions in England 2009/10
Latest figures released from ONS show that between 1991 and 2009 prescriptions dispensed for antidepressants increased by 334 per cent in England, from 9.0 million in 1991 to 39.1 million in 2009. In 2009/10 more than 1 in 10 adults (11%) in England were diagnosed with depression. ONS analysis also shows that women (21.5%) are more likely to have at least one common mental disorder – such as depression or anxiety – than men (13.6%).

**Increased use of specialist mental health services**

In 2009/10 the number of people spending time in an NHS mental health hospital increased for the first time since 2003/04-2004/5 by 5.1% to 107,765. The rise was due to an increase of 30.1% in the number of people being detained in hospital under the Mental Health Act (MHA) - from 32,649 in 2008/09 to 42,479 in 2009/10. As a percentage of patients in NHS mental health hospitals, those who were compulsorily detained under the MHA rose to nearly 39.4% in 2009/2010 – up 7.6 percentage points from 2008/09. As the number of those detained in hospital via the criminal justice system also continued to rise, the figures suggest NHS mental health hospitals are increasingly being used to care for patients who are a risk to themselves or others.

The Mental Health Bulletin 2009/10 shows:
- Over 1.25 million people were recorded as using NHS specialist mental health services in the year – the highest number since the data collection began in 1991.
2003/04 and a 4.0% increase from 2008/09. Of these people 8.5% spent time in hospital.

- The average number of days spent in hospital during the year per patient was 68 days for women and 78 days for men.
- The number of women detained under the MHA who came into hospital via prison or the courts was 830, an estimated rise of 86.5% from 2008/09. The number of men in this category rose by 48% from 1,982 to 2,935.

A warning from Greece on reducing health care costs

Greece has been affected more by the financial crisis than any other European country. As a result of high unemployment and austerity measures the picture of health in Greece is disturbing, yet it may still take several years for the true picture to immerse. There has been a rise in people reporting their health to be poor, an increase in drug use which has been linked to the rise in HIV infections whilst Budget cuts in 2009 and 2010 have resulted in the loss of a third of the country’s street-work programmes. Suicides have also risen along with a rise in violence, homicides and thefts.

Yet Greeks are experiencing difficulties accessing health care. There have been about 40% cuts in hospital budgets, understaffing, reported occasional shortage of medical supplies, and bribes given to medical staff to jump queues in overstretched hospitals. At the same time there was a 24% increase in public hospital admissions in 2010 compared with 2009 and 8% increase in the first half of 2011 compared with the same period in 2010, partly fuelled by fewer patients using private hospitals. From 2007 to 2009 there was a 15% significant increase in people not going to a doctor or dentist despite feeling that it was necessary, (odds ratio 1.15, 95% CI 1.02-1.30 for doctors; 1.14, 1.01-1.28 for dentists’ visits). This was mostly due to long waiting times (1.83, 1.26-2.64). Greater attention to health and healthcare access is required.90

Under-funding of adult social care could increase hospital admissions

Tough spending settlement for local government suggests that a funding gap of at least £1.2 billion could open up by 2014 unless all councils can achieve unprecedented efficiency savings. The consequences are that even fewer people will receive the care and support they need. This will have knock-on effects for people needing NHS care as there will be more emergency admissions to hospital, delayed discharges and longer waits for treatment.115

Furthermore, it is predicted that care home closures could mean that over the next decade, up to 100,000 frail older people could be left isolated at home – or end up being admitted to hospital. Even if just a quarter were admitted to hospital it would still cause serious problems for the NHS.116

Alcohol related hospital admissions

In all LAs that are represented in this report have increased their alcohol related admissions rate before and after the recession most peaking between 2009/10 Q4 and 2010/11 Q2 after which rates started to show a decline. Liverpool generally had the highest rates of alcohol related admissions that increased from 725 per 100,000
during 2008/09 Q2 at the start of the recession to 823 per 100,000 during 2010/11 Q2 when it reached its highest point making a 11.9% increase.
**Summarising the main health impacts of the economic downturn**

From the Whitehead and Dahlgren diagram (in fig 1) the key influences on health can be put in a table form as below and used to plot the determinants on health in HIAs.

**Table 6: Key Areas influencing health**

<table>
<thead>
<tr>
<th>Biological factors</th>
<th>age, sex, genetic factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal / family circumstances and lifestyle</strong></td>
<td>family structure and functioning, primary secondary / adult education, occupation, income, risk taking behaviour, diet, smoking, alcohol, substance misuse, exercise, recreation, means of transport (cycle / car ownership)</td>
</tr>
<tr>
<td><strong>Social environment</strong></td>
<td>culture, peer pressures, discrimination, social support (neighbourliness, social networks / isolation), community /cultural / spiritual participation</td>
</tr>
<tr>
<td><strong>Physical environment</strong></td>
<td>air, water, housing conditions, working conditions, noise, smell, view, public safety, civic design, shops (location / range / quality), communications (road rail), land use, waste disposal, energy, local environmental features</td>
</tr>
<tr>
<td><strong>Public services</strong></td>
<td>access to (location / disabled access) and quality of primary / community / secondary health care, child care, social services, housing / leisure / employment social security services, public transport, policing, other health relevant public services, non-statutory agencies and services</td>
</tr>
<tr>
<td><strong>Public policy</strong></td>
<td>economic / social / environmental / health trends, local and national priorities, policies, programmes, projects</td>
</tr>
</tbody>
</table>

*Source: Merseyside Guidelines for Health Impact Assessment*
Table 7: Priority positive health impacts from the economic downturn

<table>
<thead>
<tr>
<th>Category of Influence</th>
<th>Predicted health impacts (Quantifiability of impacts (Q) qualitative; (E) estimable; (C) calculable)</th>
<th>Certainty of Impact (D) Definite; (P) Probable; (S) Speculative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leisure</td>
<td>Increase in leisure time as working hours reduced (Q)</td>
<td>P</td>
</tr>
<tr>
<td>Income</td>
<td>As income reduces a decrease in hazardous health behaviours such as alcohol and smoking these if these substances are not cheaply available (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Decrease in hazardous health behaviours (E)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decrease in traffic accidents and fatalities as less miles travelled due to cost of fuel (C)</td>
<td>D</td>
</tr>
<tr>
<td>Social Support</td>
<td>Members of social organisations are protected from adverse health effects of economic crisis (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Informal social welfare provides opportunities to borrow money, provides food, shelter, advice on sources of food (Q)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Crisis may offer possibilities to strengthen social capital, is protective of health (Q)</td>
<td>(S)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>More people reported to be growing own fruit &amp; vegetables. (E)</td>
<td>(S)</td>
</tr>
</tbody>
</table>
### Table 8: Priority negative health impacts from the economic downturn

<table>
<thead>
<tr>
<th>Category of Influence</th>
<th>Predicted health impacts (Quantifiability of impacts (Q) qualitative; (E) estimable; (C) calculable)</th>
<th>Certainty of Impact (D) Definite; (P) Probable; (S) Speculative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of income</td>
<td>Unemployed are almost twice as likely as population average to experience persistent poverty over a four-year period. (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Long-term unemployment can lead to poor mental health (C)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Job loss associated with increase in acute CVD (E)</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in alcohol-related deaths (C)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in suicides (C)</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Rise in fuel poverty (E)</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Rise in poor diets/food poverty (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rise in households living in poverty (E), Child poverty increase (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Rising health inequality between rich and poor (E)</td>
<td>P</td>
</tr>
<tr>
<td>Young</td>
<td>Unemployment: Can have a scarring effect on future employment prospects and wages. (E)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Parasuicidal episodes are up to 25 times more likely for unemployed young men. (C)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>They are at a higher risk of getting mental health problems (C)</td>
<td>P</td>
</tr>
<tr>
<td>NEETs</td>
<td>Those with low skills more likely to be unemployed (E) and unemployment (from survey data) :</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Can cause arguments with family (Q)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Drove some to drugs &amp; alcohol (Q)</td>
<td>P</td>
</tr>
<tr>
<td>Vulnerable groups</td>
<td>Disabled, ethnic minorities, those living below the poverty line, some women and single mothers (and their children), older people – normally at a disadvantage, their health can be further compromised &amp; suffer an unequal recovery. (E)</td>
<td>D</td>
</tr>
<tr>
<td>Ethnic minorities</td>
<td>Rise in unemployment or working in precarious insecure, low paid employment. (E)</td>
<td>P</td>
</tr>
<tr>
<td>Education</td>
<td>Efficiency savings in schools could impact on classroom behaviour and exam results. (Q)</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td>Changes in funding may reduce women’s access to further/higher education (Q)</td>
<td>S</td>
</tr>
<tr>
<td>Social support</td>
<td>This is tested in economic downturns with different groups fighting for scares resources (Q)</td>
<td>S</td>
</tr>
<tr>
<td></td>
<td>Economic downturn is probably increasing the social exclusion of vulnerable groups if they have to sacrifice social activities (Q)</td>
<td>P</td>
</tr>
<tr>
<td>Public policy</td>
<td>Austerity measures will impact most on poor and</td>
<td>D</td>
</tr>
<tr>
<td>Category of Influence</td>
<td>Predicted health impacts (Quantifiability of impacts (Q) qualitative; (E) estimable; (C) calculable)</td>
<td>Certainty of Impact (D) definite; (P) probable; (S) speculative</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Public services</td>
<td>Increase in anti-depressant prescribing (C)</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Reductions in LA funding to Adult social care could increase could increase isolation of vulnerable adults (E) and increase hospital admissions and bed-blocking (C)</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>Increased use of specialist mental health services (E)</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Increases in alcohol related hospital admissions particularly among young (E)</td>
<td>D</td>
</tr>
</tbody>
</table>
How can public services mitigate the effects of the economic downturn?

Total Place

According to the rationale behind the Total Place initiative, the impact of the economic downturn means all of the public sector needs to find radical new solutions to not only deliver better value for money, but also better local services more tailored to local needs. Total Place is an initiative that looks at how a ‘whole area’ approach to public services can lead to better services at less cost. It seeks to identify and avoid duplication between organisations – to redesign the way public services are planned and delivered and provide both service improvement and efficiency at the local level. There are 13 pilot areas participating in the scheme, each area ensuring a diverse mix of economic, geographical and demographic profiles. Total Place concepts are increasingly a part of policy responses to a range of problems, including the effects of the financial crisis on neighbourhoods.

Box 1: Total Place case study

Hull City Council, in an area that has suffered more than most from the economic crisis, is responding with a number of initiatives, including a regularly updated ‘Place Shielding Action Plan’. This has measurable targets, and individually named departments taking a lead in specific areas such as business support programmes, supporting local government suppliers, supporting families and individuals through access to housing, finance and facilitation of welfare benefits, tackling unemployment and developing skills, advising the voluntary and community sector and, providing community leadership and community safety.

Preventing mental health problems

Economic downturns result in smaller changes in the mental health of the population in countries with strong social safety nets. Research by the World Health Organisation suggests that mitigating the mental health effects of economic crises depend on government action in 5 key areas:

- **Active labour market programmes** – to enable the unemployed to find work includes education and training opportunities to re-skill; special programmes for young people in transition from school to work particularly apprenticeship-type which offer most mental health benefits.
- **Family support programmes** – to protect low income families from further economic strain. Includes support for the costs of children and other dependants as well as support for maternity and parental leave.
• **Control of alcohol prices and availability** – this has proved to be the most effective and cost-effective in reducing alcohol consumption and associated harm.\textsuperscript{120}

• **Primary care for the people at high risk of mental health problems** – includes improved responsiveness to changes in people’s social, employment and income status and early recognition of mental health problems, providing psychological support can modify the effects of unemployment and indebtedness. Promoting problem-solving skills may protect against depression and suicidal behaviour.

• **Debt relief programmes** – can help people who are suffering from the stress of excessive debt. Debt advice helps individuals to improve their financial situation and may also improve their mental health. Community support agencies should be adequately resourced to help people overcome problems arising from job loss, debt, and mortgage arrears.\textsuperscript{93} People can receive this through a referral from primary care called social prescribing. [See examples of good practice for some local schemes]

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**Box 2: Active labour market programmes (ALMP)**

These aim to improving the prospects of unemployed people finding employment and include public employment services, labour market training, special programmes for youth in transition from school to work and labour market programmes to provide or promote employment for unemployed people and those with disabilities. ALMPs include resilience-building mental health promotion programmes. Group psychological support for unemployed people promotes mental health and increases re-employment rates. Furthermore, these have been found to be cost-effective providing savings for public-sector providers of social welfare benefits and employers alike through increased rates of employment, higher earnings and fewer job changes.\textsuperscript{35}

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The Cardiff School of Social Sciences recommends:\textsuperscript{10}

**Employers should be encouraged to develop strategies and approaches that address uncertainty, anxiety and job stress.**

‘Employers should manage concerns about future downsizing and possible redundancies in an open and transparent way. Where possible, HR departments should offer careers advice and training to highlight potential alternative careers and opportunities. Changes to working hours and work demands should be kept to a minimum where possible. Interventions to support people at risk of becoming unwell due to stress should be considered. This may protect people at risk of involuntarily and permanently exiting the labour market. Counselling and advice should be made available, or at least the need for this support to be recognised and acknowledged, for employees who are experiencing other disadvantage as a result of the economic downturn.’

Mind’s recommendations for improving access to debt advice for people with mental health problems:\textsuperscript{121}
• **Improved access to affordable sources of credit.** For instance, local authorities and other community organisations to assist credit unions in increasing accessibility and credibility by helping with accommodation, developing partnerships and where possible, providing funding to support the development of credit unions.

• **Better regulation of bailiffs.** For example, all statutory agencies that use bailiffs to include disability equality duty specifications in their procurement contracts.

• **Training for health and social care professionals so that they can identify debt triggers and sources of help for money problems.** In particular, mental healthcare professionals to have the basic knowledge necessary to intervene effectively before a crisis emerge. This would involve knowing the danger signs, knowing where to signpost the individual for more specialist debt advice and working collaboratively with the debt advisers.

• **Health and social care professionals to work with creditors and debt advisers when supporting clients who are experiencing problem debt.**

• **Advisers who are able to provide information about debt and welfare benefits to be based at GP surgeries.**

• **Development and dissemination of a guide to money management for people with mental health problems to be distributed through GP surgeries, hospitals, community health services and third sector mental health organisations.**

• **Improved access to money and debt advice services.**

Furthermore, social prescribing approaches should be explored for instance offering advice on prescription or gardening on prescription to improve mental health problems and wellbeing.

### Minimising the effects of reduced public services

The Audit Commission recommends Councils should ensure:

• They **avoid complacency over the recession’s impact**, since the most substantial pressures have yet to emerge;

• **fully understand their economy, and the impact of the recession** on businesses, people, capital developments and demand for services;

• **work with local partners**, business leaders, property developers, neighbouring authorities and regional bodies to gather intelligence and agree a strategic response; and

• **Implement a strategy** that has clear objectives, is tailored to local issues and focuses on both the social impact and the future recovery.

A paper from the Joseph Rowntree Foundation makes suggestions on what should be the priorities to lessen the impact on deprived neighbourhoods:

• At the very least **plans for cuts should be assessed and monitored for their likely impact on vulnerable groups and neighbourhoods.** [See Box 2 for description of vulnerable neighbourhoods]

• **Sustain the recent gains in neighbourhood conditions** – from neighbourhood regeneration represents good value for money. Local agencies need to plan ahead to sustain new buildings, improved services and strengthened community
organisations through difficult times. LA and partnership schemes to help low-income home-owners with house maintenance. In partnership with owners provide: advice, training and schemes such as: handy people, discounts and tool loans could prevent home and area decline.

- **Maintain neighbourhood renewal activities**
- **Maintain and expand the following services:**
  - local job creation – encouraging use of local labour; allowing people to work for voluntary organisations whilst claiming benefits
  - employment and training support
  - services for young people
  - public and semi-public transport
  - crime prevention activities
- **Consult on difficult issues**
- **Monitor the impact of actions**

The Cardiff School of Social Sciences recommends:

**Pooling resources:** The health sector, local authorities and the third sector to identify mechanisms which pool resources across localities for maximum health benefit.

Furthermore according to Michael Marmot, in a deteriorating economic climate, every policy in local government to be tested for its positive impact on health.

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**Box 3: Which neighbourhoods are the most vulnerable to the effects of the recession?**

- **Communities with high unemployment and large increases in unemployment** - this will include those contained in the top 10% of communities claiming Job Seeks Allowance (JSA). When unemployment in a ward reaches 23-24% that seems to be a tipping point associated with a more sharp increase in difficulty of getting out of poverty and worklessness. Also absolute numbers of people affected are important too. Where this is large these areas are likely to experience the biggest knock-on effects of recession and to require the biggest response.

- **Communities that have been relatively disadvantaged for decades** – these areas risk falling back further in the economic downturn as regeneration programmes come to end and are not replaced.

- **Communities that have seen high proportionate increases in JSA claims during 2005-09**

- **Any of the above, located within more advantaged areas or LAs where disadvantage is very widespread** – some local authorities in these advantaged areas may be complacent about the effects of the recession, and might not realise that their areas contain hard-hit communities. Conversely, individual hard-hit communities in areas where many are affected may have special problems and may struggle for recognition or priority. In Liverpool 38% of communities had claim rates that put them in the 9th or 10th highest deciles nationwide in 2009. The fact that a few communities in this group had much higher rates than others, or had experienced a recent increase, could be overlooked.
Communities hard hit by housing problems

Protecting front-line services for the disabled population
Following court rulings, it is recommended that a thorough and full consultation is carried out when considering cuts to services, or changes to eligibility criteria.

Demos has identified some elements common to the local authorities they reviewed who are coping well to local budget cuts. By applying these principles (below) a number of benefits have been identified. These include:

- **Co-production** – involving services users in designing and planning their services, and in some cases delivering it. Codesigning services with disabled people can lead to improved outcomes at lower costs.
- **A capabilities approach to disability** – looking at people’s strengths and promoting what they can do, rather than a deficit model, which focuses on what people cannot do for themselves.
- **A strategy of progression or ‘just enough support’** – where people gradually rely on less formal services and more community-based services. Using alternatives to paid staff as part of an overall package of support may also provide opportunities for more efficient use of resources for many people; improve independence and quality of life whilst reducing costs.
- **A move towards more integrated services**, bringing in care, health and often housing and leisure. Integration of services can significantly reduce cost in administrative and back office functions as well as improving outcomes by creating more seamless and jointly commissioned packages of care.
- **A commitment to personalisation**, not as a cost-cutting measure, but as a foundation on which these other strategies can be built around. Designing and planning services around the individual and giving people choice and control over their support are necessary to the development of principles above. Giving people budgetary control through ‘personal budgets’ can lead to more efficient use of resources, but this should not be at the expense of declining engagement with public services.
- **Outsourcing** – creating arm’s length trading organisations to deliver care services independently from the council. This gives the outsourcing organisations independence allowing them to innovate and become more efficient, while returning dividends to their sole shareholder – the local authority.
- **Gathering data and conducting impact assessments**. Developing effective ways to gather data enables an accurate picture of how many disabled people live in an area, where they live and what services they rely on. Robust impact assessments of LA budgetary decisions ensures the cumulative impact of the full range of local cuts (not just social care) is considered in relation to the wellbeing, social inclusion and independence of disabled people.

Young People, particularly those ‘Not in Education, Employment or Training’ (NEET)
The Private Equity Foundation has developed an action plan for improving performance on tackling NEET issues by focussing on prevention and better coordination.

**Reform commissioning:** Provide improvements in commissioning through:
- Better collaboration between local authorities and service providers
- Greater focus on value by developing commissioning capabilities
- Creating local markets for NEET services
- Adopting standard processes to reduce administration

**Grow the best provision:** To create more networked commissioning and business support for the best providers.

**Foster better links into employment:** The school curriculum needs to prepare young people for the world of work through better links, high quality work experience and more routes into work e.g. apprenticeships. Make it easier for employers to engage with young people, particularly those most at risk of becoming NEET.

**Support targeted case management for those most at risk:** Many children face a challenging pathway through numerous services and interventions. An integrated case management approach is needed to improve coordination.

**Improve information on local provision:** To record standardised performance metrics, establish guidelines for setting benchmarks and advocate good practice locally.

**Increase knowledge of what works:** Ideally to establish an anonymous database of the cost effectiveness of intervention (as maintained by NICE in the healthcare sector) and publish standard guidelines on what data funders should track to encourage the analysis and dissemination of best practice.

The Cardiff School of Social Sciences recommends:

**Protecting and developing services intended to support vulnerable children and young people**

Services that support vulnerable young people into employment, training and education need to be protected and enhanced. Those who are NEET and children with significant social needs may need more intensive and targeted support.

**Interventions to promote and strength social relationships that are protective to health**

A review of evidence, discussion and debate within the North West with key sector representatives and interviews with health and other professionals has recommended supporting effective interventions, which include:

- those that strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. support for parents, support for older people, for those who are homeless, those who have mental health problems, those who have learning difficulties, people in transition e.g. from prison to the community, leaving care, facing redundancy
- those that build and enable social support, social networks and social capital within and between communities e.g. reducing material inequalities, tackling
discrimination, improving the physical environment, especially for children and young people, access to green, open spaces, reducing motor vehicle traffic in residential areas

- those that strengthen and/or repair relationships between communities and health and social care agencies e.g. enhancing community control through co-production, timebanks, asset sharing or transfer
- those that improve the quality of the social relationships of care between individuals and professionals e.g. practice that avoids social disparagement

Examples of good practice include:

- interventions that support family and early years e.g. Sure Start
- strengthening the home learning environment and adolescent transition
- building social capital for children and older people e.g. liveable streets, stop and chat spaces
- reducing environmental barriers to social contact: reducing motor vehicle traffic, access to green, open spaces, affordable, accessible transport
- asset sharing e.g. through co-production, social return on investment measures, credit unions, social enterprise
- protecting/reclaiming public space e.g. challenging restricted use of public areas like shopping malls in Business Improvement Districts; landshare schemes to open up land for community cultivation or bringing together those with gardens and those without collective opportunities for healthy lifestyles e.g. social prescribing/community referrals; green gyms, food production/distribution, lifelong learning

Action for public authorities to promote vulnerable groups’ equality and human rights

A human rights and equality impact assessment of the public spending cuts on women in Coventry made the following suggestions.74

- Public authorities (Local Authorities, Commissioners and service providers) have legal obligations to promote equality and not to breach human rights. In order to do this effectively they need to consider the potential impact of all budget cuts on equality and human rights and carefully monitor the actual impact
- To ensure co-ordination of policies and practices, where multiple agencies have an impact on a particular issue
- To take account of the combined impact of different cuts on particularly vulnerable groups in their assessments and monitoring
  - To assess the impact of job losses, pay freezes and cuts to childcare the following areas to be monitored in local areas:
    - Level of job losses among women and men
    - Overall employment rates among women and men
    - Pay gap between women and men
    - Childcare provision
  - With regard to housing the following areas to be monitored:
    - The gap between actual rents and the amount paid by local housing allowance (LHA) and how this changes over time
    - The quantity of private rented accommodation in local areas at LHA rates or below
- The numbers made homeless in local areas and housed by the Council
- The impact of changes to LHA (and other benefits) to the household budgets of particularly vulnerable and disadvantaged groups
  - The impact of the changes to benefits and taxes and the harsher sanction regime to be monitored to assess:
    - The long term impact of the changes on gender equality
    - The impact of the changes on the human rights of the poorest women and other vulnerable groups
  - With regard to education the following areas to be monitored for their impact on women:
    - The number/percentage of women who are accessing further and higher education courses after the implementation of cuts
    - Other negative impacts on women of reduced support and funding for further education (e.g. ability to pay back student loans)
    - Cuts and reduction of support services in schools and the indirect impacts of this on women
  - The impact of the cuts on women’s safety to be monitored on an ongoing basis including:
    - Levels of reported violence against women, including through the British Crime Survey and to local agencies as well as reports to the police
    - The number of successful prosecutions
    - The degree to which services are able to provide support to victims of violence including shelter, counselling and other forms of support
    - Whether changes to benefits, legal aid and other forms of support are constraining women from leaving violent relationships or otherwise negatively impacting upon them
- Monitoring required with regard to the health services
  - Which healthcare services are reduced/removed as a result of the budget cuts and changes to the delivery of services
  - The number of staff who lose their jobs
  - Cuts to organisations who currently rely on healthcare funding
  - The disproportionate impact of all the above on women and whether there are human rights impacts
- Monitoring required with regard to legal aid services
  - Any decrease (in type and number) of cases in areas where legal aid is no longer available
  - The impact of changes to access and eligibility requirements on the cases that are brought through the legal aid system
  - Lack of availability of advice for women seeking legal help
  - The impact of any of the above on the rights of women
  - How other cuts to funding of legal advice services (e.g. City Council or Equality and Human Rights Commission funding) may impact upon the situation.
- To pay due regard to the role played by women’s organisations and voluntary organisations providing services to women in tackling discrimination and in protecting women’s human rights. Monitoring required:
  - The level of (reduction in) funding for women’s organisations and voluntary organisations providing services to women as compared to other voluntary organisations in Coventry
The impact of any reduction in funding on these organisations and their provision of services to women
The impact on women who have lost access to services or had services reduced

**Action to improve diets and reduce fuel poverty the during economic downturn**

- Provide access to ‘bag a bargain’ schemes that have been made available in some Sure Start children’s centres, where people can buy locally produced reasonably priced fruit and vegetables
- Knowsley ‘veggy van’ service that provides fresh cheap fruit and vegetables (supported by Knowsley NHS) to be made more widely available and replicated in other areas
- Targeted information and ideas on how to retain a balanced diet on a low budget have been provided in children’s centres and this is also an approach that might be extended to the wider community.\(^{109}\)
- Gardening on prescription may encourage people to source their own fruit and vegetable whilst also helping to combat depression, anxiety and low moods. This is currently offered to patients in Southampton through a Health and Wellbeing grant. \(^{111}\)
- Follow the example of the Liverpool Healthy Homes Programme to advise and support people at risk of fuel poverty and giving advice on keeping homes warm enough through the winter.

**Wellness services**

Public services now have to do much more for less. Wellness services that tackle the root causes of ill-health, particularly inequalities in health could make considerable savings.

Wellness services take a “whole person” centred approach.\(^{122}\) They are described as “those that specifically promote health and wellbeing, (including the dimensions of wellness: physical, intellectual, emotional/psychological, social, spiritual, occupational and environmental) rather than diagnose and treat illness. This could be via healthy lifestyles, psychosocial interventions for individuals, families or groups. This might include a combination of smoking cessation, weight management, alcohol brief interventions, physical activity pathways, health trainers, social prescribing / referral, psychological well being interventions, e.g. mindfulness and stress management.”

A recent Liverpool Public Health Observatory report\(^{122}\) has reviewed these services and is free to download from: [http://www.liv.ac.uk/PublicHealth/obs/publications/report/Wellness_Services_cost-effectiveness_review_Final_Report.pdf](http://www.liv.ac.uk/PublicHealth/obs/publications/report/Wellness_Services_cost-effectiveness_review_Final_Report.pdf)

This report reviews the regional and National evidence base regarding any programmes that commission on a “whole person” centred approach and potential
benefits that might be achieved in terms of the economics and overall patient/public experience and quality issues. This review also contains many examples of good practice and guidance for setting up these services.

Examples of good practice

Liverpool Healthy Homes Programme

The Healthy Homes Programme (HHP) is run jointly by Liverpool City Council and the NHS Liverpool Primary Care Trust (PCT). It aims to prevent ill health and injury resulting from poor quality housing conditions.

What we do

Healthy Homes Advocates visit properties in the areas with the greatest health and housing support needs and gather information about the occupants and their health needs, as well as the condition of their homes. They can then provide free help and advice to residents on removal or prevention of hazards that can improve their health and wellbeing.

Advice is given on:
- Health proofing homes (from excess cold, damp and mould).
- Home safety (to prevent falls on stairs, flat surfaces and hot surfaces and identifying any slip, trip or fall hazards).
- How to access services provided by various support agencies such as Age Concern or the Benefit Maximisation Service.
- Healthy eating.
- Fuel poverty and keeping your home warm enough through the winter.
- Maximising income.

Enforcement

HHP has a team of Environmental Health Officers who can use enforcement powers to make unwilling landlords improve properties if there are serious health and safety risks to their tenants. Where landlords fail to carry out the necessary work Environmental Health Officers can prosecute them if they consider housing conditions to be a danger on the basis of health and safety standards and the landlord is unwilling to take the appropriate remedial action.

Partners

HHP work closely with a wide network of partners who provide support services to local people. This means HHP can put residents in contact with organisations who can help them. For example, HHP can contact:
- Merseyside Fire and Rescue Service to fit smoke alarms in the property.
- Roy Castle Fag Ends to get in contact with you to help you give up smoking.
- Citizen Advice Bureau helps people resolve their legal, money and other problems.
http://www.liverpool.gov.uk/council/strategies-plans-and-policies/housing/healthy-homes-programme/
Liverpool Community Food workers

Liverpool PCT employs a team of Community Food workers who run educational ‘taste and eat’ sessions and provide training to members of the community on basic food hygiene and healthy eating on a budget. All of their work is focused on the needs of the community they work in. They work closely with community groups throughout Liverpool, health professionals and Sure Start to bring healthy eating messages to a wide audience.

All staff in the food worker teams live in Liverpool and most live in the communities in which they work. Because the food workers live locally and understand the realities of living in their own communities, they are credible and valid sources of information on food and health. They are able to use local knowledge to motivate people to make changes to family eating habits. The project has also helped local people to begin a career in the NHS, providing training and qualifications on food and health so each Food Worker is able to provide credible and safe advice on what to eat, to promote health particularly in an economic downturn.

www.tasteforhealth.com

Health Impact Assessment of the health impacts of Liverpool City Council service changes on older people

Liverpool Community Health (LCH) Trust has commissioned IMPACT, University of Liverpool, to undertake a rapid, concurrent Health Impact Assessment (HIA) of the health impacts of Liverpool City Council (LCC) service changes on older people who are resident in Liverpool and who use LCH services.

The HIA will inform understanding of how services are changing in the City, the potential impact of those changes for LCH service users aged 55 years and over and consider how new ways of working can be explored.

The HIA will present recommendations designed to provide opportunities for community engagement and participation in service provision, bringing new ways of working in order to maximise potential positive benefits to health and well-being, as well as ways to minimise potential negative impacts. A HIA report for Liverpool Community Health Trust will be used to inform decision making and commissioning intentions.

Knowsley Council quarterly Resilience Monitor

The Policy, Impact and Intelligence Division at Knowsley Council is producing a comprehensive quarterly monitor of the main indicators of the economic pressure on people living in Knowsley. This monitor includes charts to illustrate:
• Key economic indicators (with a coloured arrow to show whether these have gone up or down or stayed the same) – bank rate, inflation using CPI, prices for food, fuel, public transport and house prices, rent and wage levels
• Labour market statistics – unemployment, redundancies, vacancies, job seekers and benefit claimants
• Benefit dependency in each of the Partnership Areas
• Levels of personal debt – council tax, personal debt and how concerned residents are about it from tracker survey, what types of debt are residents seeking advice about from CAB and credit union data, and how this varies across the borough
• New homes and empty homes
• Housing challenges facing Knowsley residents – where people are looking to buy in Knowsley, situation facing buyers – average house price, % of first time buyers who would be priced out from buying in their ward, pressure on social housing – number of repossessions, rate per 1000 households, comparison of weekly rent compared to social housing, number of applicants/transferees on to the council
• Town centre vitality – number and % of vacant shops, number of car parking town centre visitors
• Geographical hotspots – benefit dependency, educational attainment / decline, crime, anti-social behaviour, low life expectancy for males and females, smoking prevalence,
• Tracker survey on how people are responding to pressure – happiness, ability to afford what makes people happy, tension, financial security, changes in financial security, community safety,
• Demography – population, ethnicity, working age employment status, homes tenure, ACORN classification by household, households in debt, repossession per 1000 households

Advice on Prescription scheme in Halton & St Helens

This is a joint project run by NHS Halton and St Helens Health Improvement Team and the local Citizens Advice Bureau (CAB). The aim of the project is to fast-track people visiting their GP with mental health problems due to social welfare issues, to appropriate support services rather than referring to psychological therapy services.

The difficult economic climate has seen many support organisations like the CAB struggle to cope with the significant rise in numbers of people seeking debt advice. Waiting times to see debt advisers have lengthened, sometimes to be in excess of 8 weeks. Problems involving debt, employment, benefits or housing issues are common topics increasingly being presented to GP’s and primary care staff. These difficulties bring about anxiety or low mood type symptoms which potentially may worsen whilst someone is waiting for a traditional clinical intervention service. NHS Halton and St Helens are currently funding six debt advisors for the CAB. The Advice on Prescription service forms part of the collaborative approach between these two organisations, and the Health Improvement Team, to provide social welfare support locally.
In the initial 12 week evaluation period 5 GP practices, the single point of access to mental services and the psychological therapy service used in the pilot, referred 35 people. Thirty-eight per cent of people referred had their level of mental health intervention stepped down, within the recognised stepped care model, as a result of the CAB helping them to manage the trigger to their distress. Furthermore, two mental health practitioners reported that two patients in crisis services had their suicidal risk level significantly reduced or eliminated as their issues were resolved by the Advice on Prescription service.

Over the next year NHS Halton and St Helens are looking to expand the service to other key partners who provide support and advice.


Welfare advice in nine GP practices in areas of high deprivation in Sefton

An evaluation of this CAB Health Outreach service demonstrated that almost half the patients referred may have had a mental health issue. There was a statistically significant reduction in the number of GP appointments and prescriptions for hypnotics/anxiolytics during the six months after referral compared to six months before. There were also non-significant reductions in nurse appointments and prescriptions for antidepressants.125
Claimant count in Merseyside and Halton

Figure 4: Job Seekers Allowance (JSA) claimants in Merseyside and Halton, Jan 05-Jul 11. % working age population.

The claimant count measures the number of people claiming Jobseeker’s Allowance (JSA) and differs from unemployment (which measures people who meet the internationally agreed definition of unemployment). The claimant count can be affected by changes to the overall benefits system. For example, from late 2008 until mid-2011 changes in eligibility rules for Lone Parent Income Support resulted in fewer lone parents (predominantly women) being able to claim that benefit resulting in more lone parents claiming JSA while they look for work. From April 2011, the Department for Work and Pensions has been re-assessing claimants of Incapacity Benefit (IB) resulting in some people who have been declared ineligible for IB claiming JSA while they look for work. The effect of this exercise on the claimant count so far is likely to have been small.58

At the local authority level, the effect of the recession on JSA claimant rate has been most severe in Liverpool, followed by Knowsley and Halton. Least affected are Wirral, St Helens and Sefton. All areas are much higher than the average for England. The rate in most areas was at its highest in January 2010. In Liverpool the JSA claimant rate increased by 2.4% of working age population (WAP) from 4.8% to 7.2% between June 2008 and August 2009.
Figure 5 illustrates that from July 2009, as the recession started to bite, there was an increase in JSA claimants who had been out of work for more than a year. Sefton increased the most as the JSA claimant counts out of work for over 1 year as a proportion of the working age population (WAP) rose by 0.6% from 0.5% in June 2008 to 1.1% in September 2011. Liverpool had the highest rate of long-term JSA claimants which reached 1.6% of the WAP.

Figure 6: JSA claimant rate in the Liverpool City Region by age of claimant, January 2005-July 2011. % working age population
Figure 6 illustrates the effect of the recession upon JSA claimant rate by age band in the Liverpool City Region Local Enterprise Partnership (LEP) that covers the boroughs of Halton, Knowsley, Liverpool, St Helens, Sefton and Wirral.

It can be seen that there is a disproportionate effect of the economic downturn on younger age groups. Between the official start of the recession in June 2008 and August 2009 the JSA claimant rate increased by 11.6% of 18 to 24 year olds and 3.2% of 25 to 29 year olds. Between June 2009 and January 2010 JSA claimant rate increased for 35-39 year olds by 3.1%. There is a lower gradual increase in the older age groups.

**Young Persons aged 16-18 Not in Education, Employment or Training in Local Authorities**

Table 9: November to January Estimated number (%) of children aged 16-18 years who are Not in Education, Employment or Training (NEET) by Region and LA 2006-7 to 2010-11

<table>
<thead>
<tr>
<th>Region</th>
<th>2006-7</th>
<th>% NEET</th>
<th>2007-8</th>
<th>% NEET</th>
<th>2008-9</th>
<th>% NEET</th>
<th>2009-10</th>
<th>% NEET</th>
<th>2010-11</th>
<th>% NEET</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>21,541</td>
<td>8.9%</td>
<td>19,567</td>
<td>7.9%</td>
<td>19,438</td>
<td>7.8%</td>
<td>17,599</td>
<td>7.3%</td>
<td>15,684</td>
<td>6.7%</td>
</tr>
<tr>
<td>Halton</td>
<td>538</td>
<td>11.8%</td>
<td>493</td>
<td>11.5%</td>
<td>1,143</td>
<td>13.2%</td>
<td>404</td>
<td>10.2%</td>
<td>348</td>
<td>9.3%</td>
</tr>
<tr>
<td>Knowsley</td>
<td>687</td>
<td>13.7%</td>
<td>695</td>
<td>15.0%</td>
<td>1,775</td>
<td>14.4%</td>
<td>437</td>
<td>10.6%</td>
<td>432</td>
<td>11.4%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2,039</td>
<td>13.2%</td>
<td>1,846</td>
<td>11.5%</td>
<td>345</td>
<td>10.4%</td>
<td>1,311</td>
<td>8.7%</td>
<td>1,180</td>
<td>8.2%</td>
</tr>
<tr>
<td>Sefton</td>
<td>870</td>
<td>7.6%</td>
<td>802</td>
<td>7.2%</td>
<td>775</td>
<td>7.6%</td>
<td>688</td>
<td>6.5%</td>
<td>584</td>
<td>5.8%</td>
</tr>
<tr>
<td>St. Helens</td>
<td>684</td>
<td>10.0%</td>
<td>585</td>
<td>8.5%</td>
<td>561</td>
<td>8.1%</td>
<td>505</td>
<td>7.5%</td>
<td>458</td>
<td>7.0%</td>
</tr>
<tr>
<td>Area</td>
<td>Total</td>
<td>Rate</td>
<td>% Change</td>
<td>Total</td>
<td>Rate</td>
<td>% Change</td>
<td>Total</td>
<td>Rate</td>
<td>% Change</td>
<td></td>
</tr>
<tr>
<td>----------</td>
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<td>-------</td>
<td>-------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Wirral</td>
<td>1,213</td>
<td>10.0%</td>
<td></td>
<td>1,122</td>
<td>9.5%</td>
<td></td>
<td>736</td>
<td>9.1%</td>
<td></td>
<td>1,025</td>
</tr>
</tbody>
</table>

Source: Department of Education
The proportion of young people aged 16-18 ‘not in education, employment or training’ (NEET) in Liverpool during and after the recession has decreased from 13.2% in 2006-7 down to 8.2% in 2010-11, but has been above the North West average. North West average has remained fairly constant over the years below the 10% level. Knowsley has had the highest average of NEETs in each year. Sefton, St Helens and Wirral have not gone over the 10% level. Both Halton and Knowsley have remained between 10-15% between 2006-7 to 2009-10.

Landlord and mortgage repossession claims and orders

To obtain a court order granting the entitlement to take possession of a property, a claimant – a mortgage lender or a landlord – must first make a claim which is then issued by a county court. Generally, the issuing process involves the arrangement of an initial hearing before a judge. At such a hearing, the court may grant an order for possession of the property immediately. This then entitles the claimant to apply for a warrant to have the defendant evicted by bailiffs, so taking possession of the property. Throughout the court process, even where a warrant for possession is issued, the claimant and defendant can still negotiate a compromise arrangement to prevent eviction. More than one order may be granted during the course of an individual case. For example, it is possible that after an initial possession order is granted, the defendant may make an application to the court for the order to be varied or set aside, which could then result in another order being made. As a result, the headline statistics on orders in these statistics are defined as the number of possession claims that lead to an order being made. This measure is more accurate than a straight count of the number of orders made, as it removes the double-counting of instances where a single claim leads to more than one order. It is also a more meaningful measure of the number of homeowners who are subject to court repossession actions. Where more than one order is made in relation to a single claim, the date and type of the first order made is counted in these statistics.
Note that the figures represent court actions for possession and not actual homes repossessed. Repossessions can occur without a court order being made, while not all court orders result in repossession taking place. Landlord and mortgage repossession claims and orders for Merseyside local authorities and Halton are illustrated in figures 5 and 6 respectively.

Figure 8: Landlord Repossession Claims and Orders in Merseyside LAs and Halton (2005-2010) per 1000 households.
In most areas there is a downward trend in claims and claims leading to orders after 2008 apart from in Knowsley where there was a slight upward trend and then a decline during 2009 and on the Wirral there was a slight upward trend during 2010.

Figure 9 Mortgage Repossession Claims and Orders in Merseyside LAs and Halton (2005-2010) per 1000 households.

There has been a sharp rise in mortgage repossession claims and orders since 2005 that peaked in 2008 at the start of the recession, after which there was a steep downward trend. A similar pattern is shown for England, but it is lower than for local areas. The numbers of claims leading to orders being made are substantially larger than the numbers of actual repossessions and the disparity between these figures
varies over time. In Merseyside the proportion of claims that have resulted in court orders has gradually increased from 67% in 2005 to 71% in 2009 and remained at 70% during 2010.

The downward step change coincided with the introduction of the Mortgage Pre-Action Protocol (MPAP) that was introduced by the government on 19th November 2008. The Protocol gives clear guidance on what the courts expect lenders and borrowers to have done prior to a claim being issued. The main aims of it were to ensure that the parties act fairly and reasonably with each other in any matters concerning the mortgage arrears, to encourage more pre action contact between lender and borrower and to enable efficient use of the court’s time and resources.

Local Fuel Poverty statistics 2006-2009

To obtain LA rates of fuel poverty, in fig. 3, a logistic regression model is created using household level data from the English Household Survey detailing whether the household is fuel poor or not (as the binary dependent variable) and matched to variables from other sources that are available for all Census Output Areas in England. Unfortunately, figures for fuel poverty 2007 are not available. However, In March 2010, a consultation with users highlighted a clear desire for these statistics to be produced annually and it is the Department of Energy and Climate Change’s (DECC) intention to produce these statistics annually in the future.

The figures above show that fuel poverty is increasing since 2006 in all areas covered by this report. Liverpool consistently has higher rates than the other local authorities in the three years 2006, 2008 and 2009. Liverpool rates have increased by 10.6% during this time. Whereas, Halton has the lowest rates in each year, which have increased by 8.7% over the same period. Knowsley has seen the biggest increase of 11.7%, from 11.7% in 2006 to 23.4% in 2009.
Children living in poverty

Table 10: Percentage of children in poverty by Local Authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Percentage of all Children in Poverty*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Halton</td>
<td>25.7</td>
</tr>
<tr>
<td>Knowsley</td>
<td>32.6</td>
</tr>
<tr>
<td>Liverpool</td>
<td>34.7</td>
</tr>
<tr>
<td>St. Helens</td>
<td>23.9</td>
</tr>
<tr>
<td>Sefton</td>
<td>19.9</td>
</tr>
<tr>
<td>Wirral</td>
<td>23.5</td>
</tr>
</tbody>
</table>

Sources: HMRC, 2010 estimates from End Child Poverty

*Percentage of Children in poverty: refers to the number of children under 20 living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of income support or (Income Based) Job Seekers Allowance, divided by the total number of children in the area (determined by Child Benefit data)

Table 11: Percentage of children in poverty by Parliamentary constituency

<table>
<thead>
<tr>
<th>Parliamentary constituency</th>
<th>Percentage of all Children in Poverty*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Liverpool, Riverside</td>
<td>47.6</td>
</tr>
<tr>
<td>Birkenhead</td>
<td>37</td>
</tr>
<tr>
<td>Liverpool, Walton</td>
<td>38</td>
</tr>
<tr>
<td>Bootle</td>
<td>35.4</td>
</tr>
<tr>
<td>Liverpool, West Derby</td>
<td>34.5</td>
</tr>
<tr>
<td>Knowsley South</td>
<td>28.9</td>
</tr>
<tr>
<td>Knowsley North and Sefton East</td>
<td>27.8</td>
</tr>
<tr>
<td>Liverpool, Wavertree</td>
<td>27.4</td>
</tr>
<tr>
<td>Wallasey</td>
<td>26.6</td>
</tr>
<tr>
<td>Liverpool, Garston</td>
<td>27.8</td>
</tr>
<tr>
<td>St. Helens South</td>
<td>26.4</td>
</tr>
<tr>
<td>Halton</td>
<td>24</td>
</tr>
<tr>
<td>St. Helens North</td>
<td>21.5</td>
</tr>
<tr>
<td>Southport</td>
<td>14.9</td>
</tr>
<tr>
<td>Wirral West</td>
<td>13.6</td>
</tr>
<tr>
<td>Wirral South</td>
<td>12.6</td>
</tr>
<tr>
<td>Crosby</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Sources: HMRC, 2010 estimates from End Child Poverty

During 2006-2010 in Sefton 1 in 5 children was living in poverty. In all other local authorities around 1 in 4 was. In the parliamentary constituency of Liverpool Riverside nearly half of children living in the area during 2007 and 2010 were living in poverty.
poverty and nearly two-thirds of parliamentary constituencies had at least a quarter of children living in poverty. The figures for each area have remained fairly constant over this 5 year period. Two-thirds of wards in both Knowsley and Liverpool in 2009 (the last ONS figures published) had a quarter or more children living in poverty. Whilst in Halton and St Helens 57% and 50% respectively were living at this level. Only 4 wards in Halton and 2-6 wards in each Merseyside LA had reached the government's target of 10% or less living in relative poverty. Therefore it will be very difficult to reach this target in all wards by 2020.

Alcohol Related Admissions

The evidence suggests that in an economic downturn unemployment and financial difficulties may lead to increased stress and mental health problems, which in turn may be associated with increased alcohol abuse and attributed disease.

Figure 11: Alcohol related admissions in Merseyside LAs and Halton by European aged standardised rate per 100,000 population

Figure 11 shows the alcohol related admission for Merseyside LAs and Halton by quarter from 2007/08 – 2010/11 (the 2010/11 are only provisional data.) In all LAs the alcohol related admissions rate was significantly higher than the England average. Sefton's alcohol related admissions were generally lower than all other LAs with one exception in 2007/08 Q2 when St Helens had a slightly lower rate. Sefton's alcohol related admissions rates were the closest to the North West average. All LAs have increased their alcohol related admissions rate before and after the recession most peaking between 2009/10 Q4 and 2010/11 Q2 after which rates started to show a decline. Liverpool generally had the highest rates of alcohol related admissions that increased from 725 per 100,000 during 2008/09 Q2 at the start of the recession to 823 per 100,000 during 2010/11 Q2 when it reached its highest point making a 11.9% increase.
Conclusions
This economic downturn is disproportionately affecting the poor and those in vulnerable groups who will be amongst the poorest, sickest or most disabled. These groups include those with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people. As economic growth continues to stagnate and harsher austerity measures are introduced, more households will be joining those on low incomes and living below the poverty line, without the sustaining influence of social protection from a strong welfare state. What all these vulnerable groups tend to have in common is a low income.

Whilst struggling in poverty or on a low income in the face of global economic shocks trying to cope with the rising cost of living, resilience is not a bottomless resource that can be freely replenished without cost in the form of increased pressures on time, high levels of stress and making sacrifices. Adapting to the rising cost of living creates a considerable stressful burden by having to economise on food, heating and travel, spending more time and effort on shopping and cooking, whilst having less nutritious food that all takes a toll on mental and then physical health. Indeed, these are stresses that are increasing in all areas covered by this report which could have a detrimental effect on physical and mental health. Excess winter deaths are three times as high in coldest homes as in the warmest. A substantial amount of evidence has shown an association between low socioeconomic status and mental health problems.

These population groups are normally at a disadvantage, but during an economic downturn their health can be further compromised, through stress, effort budgeting and coping with the unfairness of their situation. They will suffer from an unequal recovery from the economic downturn which will in turn increase inequalities in health and so the cycle of poor health will continue. The economic crisis is probably increasing the social exclusion of vulnerable groups if in coping with increasing demands on their resources they have to sacrifice social activities.

Evidence from previous economic recessions shows that those with disabilities, ethnic minorities and low skilled workers will experience an increase in and longer duration of unemployment. During this economic downturn young people are also experiencing disproportionately high unemployment that can have a lasting adverse effect on employment prospects and future earnings particularly for low-skilled or those not in education or training. Young unemployed have a higher risk of getting mental health problems, such as depression, than young people who remain employed. Absolute and relative child poverty is expected to increase through government changes to personal taxes and state benefits, putting them at a greater risk of suffering from mental health issues and behavioural problems and may also be at risk of performing badly at school. Social mobility could be affected too by efficiency savings in schools as children from disadvantaged backgrounds may not have the access to the support they need to progress to higher education.
It is expected that at the very least the economic crisis will bring more poverty, more foreclosures on houses, more homelessness and related housing problems. Liverpool Local Authority is already within the top 20 LAs with highest levels of child poverty across England. Most people who experience homelessness or the threat of homelessness will suffer from stress related illnesses and spend most of their time worrying.

Local areas too show low economic resilience and are all ranked within the bottom third in the country as the north south divide increases. Over four years Liverpool has had the highest workless rate which includes a high proportion of the sick and disabled. Unemployment has increased most in high manufacturing and high rented areas. Public sector job losses are also disproportionately higher in poorer areas, which in turn are more dependent on public sector services and welfare benefits that are both being cut.

Evidence consistently shows that unemployment, which increases in economic downturns, is linked to poorer health, though the psychological effects and prolonged stress of unemployment and the material consequences of a reduced income. Those working in precarious employment with little or no employment and welfare rights (such as immigrants) suffering a daily existence of low paid, high-strain, temporary employment, will make them ill prepared and least resilient to the additional negative health impact of unemployment.

Rapidity of economic change appears to be a key hazard to health. There is consistent evidence that the economic downturn may increase suicide and alcohol-related death rates. Worries about job losses have made stress the most common cause of long-term sick leave in Britain with employers planning redundancies are most likely to see a rise in staff mental health problems. People suffering from financial strain will be particularly at risk of mental health problems. In some studies unemployment is linked to a higher incidence of risky health behaviours, in particular among young men including problematic alcohol use and smoking. Thousands more young people, who are unable to feed their family, are turning to food banks. Poverty is increasingly associated with obesity and other nutrition related conditions. For infants the impact of a poor diet in the first two years of life is irreversible.

At risk to cuts in public spending are services that promote long-term health and well-being (such as: adult social care, libraries and community centres) and their reduction or closure could threaten the health of the vulnerable and the elderly. The cuts in welfare and public sector services could widen health inequalities between the rich and poor – who already face fewer years in life expectancy and fewer disability free years.

Major reductions in LA budgets will likely result in reductions in funding for adult social care. The consequences are that more vulnerable adults could be isolated at home, if the predicted closure of adult care homes takes place or be admitted to hospital causing serious problems for the NHS. The use of anti-depressants has soared as the economic downturn started to take effect, leading to concerns that GPs were not addressing the underlying cause of the problems. Furthermore, the use of specialist mental-health services has increased.
The maintenance of social welfare programmes seems to be a key determinant of future population health that should be taken into account in ongoing economic debates. The economic crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient.
Recommendations to Local Authorities, Commissioners and Service Providers

To minimise the effects of reduced public services:
- At the very least plans for cuts should be assessed and monitored for their likely health impact on equality and human rights, vulnerable groups and neighbourhoods.
- Ensure co-ordination of policies and practices, where multiple agencies have an impact on a particular issue.
- Be aware that there will be long-term impacts of the recession even when entering the recovery.
- Fully understand your economy, and the impact of the recession on businesses, people, capital developments and demand for services.
- Work with local partners, business leaders, property developers, neighbouring authorities and regional bodies to gather intelligence and agree a strategic response; and
- Implement a strategy that has clear objectives, is tailored to local issues and focuses on both the social impact and the future recovery.
- Consider using a ‘whole area’ Total Place approach to public services to shield areas from the economic downturn - this can lead to better services at less cost such as Hull’s ‘Place Shielding Action Plan’.
- Consider integrating lifestyle/prevention services into whole person centred wellness services.
- Improve information on local provision: To record standardised performance metrics, establish guidelines for setting benchmarks and advocate good practice locally.
- Increase knowledge of what works: Ideally to establish an anonymous database of the cost effectiveness of interventions (as maintained by NICE in the healthcare sector) and publish standard guidelines on what data funders should track to encourage the analysis and dissemination of best practice.

To mitigate the mental health effects of the economic crises consider:
- Using active labour market programmes to enable the unemployed to find work.
- Encouraging employers to develop strategies and approaches that address uncertainty, anxiety and job stress.
- Family support programmes to protect low income families from further economic strain.
- Community support agencies to be adequately resourced to help people overcome problems arising from job loss, debt, and mortgage arrears.
- Improved access to affordable sources of credit by supporting credit unions or their development.
- Better regulation of bailiffs. All statutory agencies that use bailiffs to include disability equality duty specifications in their procurement contracts.
- Training for health and social care professionals so that they can identify debt triggers and sources of help for money problems.
- Encouraging health and social care professionals to work with creditors and debt advisers when supporting clients who are experiencing problem debt.
• Having advisers who are able to provide information about debt and welfare benefits to be based at GP surgeries and hospital clinics
• Development and dissemination of a guide to money management for people with mental health problems to be distributed through GP surgeries, hospitals, community health services and third sector mental health organisations
• Social prescribing approaches to be explored - for instance, offering welfare advice on prescription, or gardening on prescription to improve mental health problems and wellbeing.
• Improved access to money and debt advice services.
• Primary care for the people at high risk of mental health problems – providing psychological support and promoting problem-solving skills to modify the effects of unemployment and indebtedness
• Control of alcohol prices and availability

Consider the following examples of good practice that promote social relationships:
• interventions that support family and early years e.g. Sure Start
• strengthening the home learning environment and adolescent transition
• building social capital for children and older people e.g. liveable streets, stop and chat spaces
• reducing environmental barriers to social contact: reducing motor vehicle traffic access to green, open spaces; affordable, accessible public transport
• asset sharing e.g. through co-production, social return on investment measures, credit unions, social enterprise
• protecting / reclaiming public space e.g. challenging restricted use of public areas like shopping malls in Business Improvement Districts; landshare schemes to open up land for community cultivation or bringing together those with gardens and those without, collective opportunities for healthy lifestyles e.g. social prescribing / community referrals; green gyms, food production/distribution, life long learning

To lessen the impact on disabled people and those at risk of chronic ill-health apply the following principles:
• Involve service users in designing and planning their services and in some cases delivering it can lead to improved outcomes at lower costs.
• Take a capabilities approach to disability by looking at people’s strengths and promoting what they can do.
• Implement a strategy of progression or ‘just enough support’ – where people gradually rely on less formal services and more community-based services may improve independence and quality of life whilst reducing costs.
• A move towards more integrated services can significantly reduce cost in administrative and back office functions as well as improving outcomes by creating more seamless and jointly commissioned packages of care.
• A commitment to personalisation, designing and planning services around the individual and giving people choice and control over their support are necessary to the development of principles above.
• Outsourcing – creating arms length trading organisations to deliver care services independently from the council to allow innovation and efficiency, while returning dividends to the local authority.
• Gathering data and conducting impact assessments to enable an accurate picture of how many disabled people live in an area, where they live and what services they rely on. Ensures the cumulative impact of the full range of local cuts is considered in relation to the wellbeing, social inclusion and independence of disabled people.
• Consider carrying out a thorough and full consultation when considering cuts to services, or changes to eligibility criteria

To lessen the impact on deprived neighbourhoods:
• Sustain the recent gains in neighbourhood conditions from regeneration
• Provide LA and partnership schemes to help low-income home-owners with house maintenance. In partnership with owners provide: advice, training and schemes such as handy people, discounts and tool loans that could prevent home and area decline.
• Maintain neighbourhood renewal activities
• Maintain and expand the following services:
  o local job creation – encouraging use of local labour; allowing people to work for voluntary organisations whilst claiming benefits
  o employment and training support
  o services for young people
  o public and semi-public transport
  o crime prevention activities
• Consult on difficult issues
• The health sector, local authorities and the third sector to identify mechanisms which pool resources across localities for maximum health benefit.

To help young people, particularly those ‘Not in Education, Employment or Training’ (NEET):
• Reform commissioning: Provide improvements in commissioning through:
  o Better collaboration between local authorities and service providers
  o Greater focus on value by developing commissioning capabilities
  o Creating local markets for NEET services
  o Adopting standard processes to reduce administration
• Grow the best provision: To create more networked commissioning and business support for the best providers.
• Foster better links into employment: The school curriculum needs to prepare young people for the world of work through better links, high quality work experience and more routes into work e.g. apprenticeships. Make it easier for employers to engage with young people, particularly those most at risk of becoming NEET.
• Support targeted case management for those most at risk as many children face a challenging pathway through numerous services and interventions; an integrated case management approach is needed to improve coordination
• Protect and develop services intended to support vulnerable children and young people into employment, training and education.
• Those who are NEET and children with significant social needs may require more intensive and targeted support.
Consider action to protect against food poverty and fuel poverty during the economic downturn:

- Provide access to reasonably priced fruit and vegetables such as: ‘bag a bargain’ schemes and Knowsley ‘veggy van’ service
- Targeted information and ideas on how to retain a balanced diet on a low budget have been provided in children’s centres and this is also an approach that might be extended to the wider community using community food workers
- Gardening on prescription may encourage people to source their own fruit and vegetables whilst also helping to combat depression, anxiety and low moods.

Ensure there is advice available to people at risk of fuel poverty (see the example Liverpool Healthy Homes Programme).
Appendix 1: List of Local Recession Indicators
Recession Indicators

Table 12: Indicators that can be used to monitor the recession

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Available from</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour market profile data Job seekers allowance claimants</td>
<td>Nomis official labour market statistics. <a href="http://www.nomisweb.co.uk/">http://www.nomisweb.co.uk/</a></td>
</tr>
<tr>
<td>Percentage 16-18 not in education, employment or training (NEET)</td>
<td><a href="http://www.education.gov.uk/16to19/participation/neet/a0064101/16-to-18-year-olds-not-in-education-employment-or-training-neet">http://www.education.gov.uk/16to19/participation/neet/a0064101/16-to-18-year-olds-not-in-education-employment-or-training-neet</a> 2010 data are an average at the end of November 2010, December 2010 and January 2011. They include all young people known to the local authority who were aged 16, 17 or 18 at that time.</td>
</tr>
</tbody>
</table>
Definition: The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income |
| Homelessness Number of households accepted and acceptances rate per 1,000 households | [http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables/](http://www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/homelessnessstatistics/livetables/)  
Quarterly and annual LAs 2003-2010 |
| Admission episodes for alcohol-attributable conditions (previously NI39)  | [http://www.lape.org.uk/natind.html](http://www.lape.org.uk/natind.html)  
Annual trend 2002-03 to 2009-10. PCT & LA |
| EPAC prescribing data for antidepressants, hypnotics (used for insomnia) and anxiolytics (anti-anxiety drugs). | ePACT.net [http://www.nhsbsa.nhs.uk/PrescriptionServices/3230.aspx](http://www.nhsbsa.nhs.uk/PrescriptionServices/3230.aspx)  
Requires registration with prescription service |
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<th>Indicator</th>
<th>Available from</th>
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<tr>
<td>Mental health hospital admissions</td>
<td>Mental Health Observatory, North East Public Health Observatory</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.nepho.org.uk/mho/diagnosis">http://www.nepho.org.uk/mho/diagnosis</a></td>
</tr>
<tr>
<td></td>
<td>(Interactive atlas 2001-2006 only MHO No longer funded?)</td>
</tr>
<tr>
<td>Emergency Hospital Admissions</td>
<td>The Information Centre for health and social care</td>
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<td></td>
<td>Clinical and health outcomes knowledge base</td>
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<td></td>
<td><a href="http://www.nchod.nhs.uk">http://www.nchod.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td>Indirectly age standardised rates; All ages</td>
</tr>
<tr>
<td></td>
<td>Financial years 2002/03 to 2008/09 LA &amp; PCT</td>
</tr>
<tr>
<td>Mortality for all cause</td>
<td><a href="http://www.nchod.nhs.uk">www.nchod.nhs.uk</a></td>
</tr>
<tr>
<td>Direct Standardised Rate</td>
<td>2007-2009 pooled data by LAs PCTs Counties</td>
</tr>
<tr>
<td>IMD</td>
<td>ONS Neighbourhood Statistics LAs 2007, 2010</td>
</tr>
<tr>
<td>% LSOAs in the 10% most deprived IMD</td>
<td>PCT publications/analysts</td>
</tr>
</tbody>
</table>
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