Using economic development to improve health and reduce inequalities in Middlesbrough

1.0 Purpose

1.1 This briefing paper has been pulled together to provide rationale for improved alignment between economic and public health strategy in Middlesbrough, in order to deliver inclusive economies and thriving population health.

2.0 Background

2.1 According to a recent Health Foundation's paper[1], "*people's health and the economy cannot be viewed independently. Both are necessary foundations of a flourishing and prosperous society*". Whilst this assertion has long been accepted academically, the interdependent link between COVID-19 and the short and long-term economic impact, has further heightened awareness of the intrinsic correlation between health and wealth.

2.2 In Middlesbrough, a key indicator of the interdependent relationship between health outcomes and economic status is the correlation between levels of deprivation and life expectancy. For instance, between the most deprived and least deprived wards in Middlesbrough (North Ormesby and Nunthorpe, respectively) there is respective 9.8 and 8.9 year gap in male and female life expectancy.

2.3 This relationship is reflected in multiple health indicators. The table below demonstrates the comparison of high-level health and socioeconomic outcomes, between Middlesbrough and the more affluent area of Richmond upon Thame. These indicators sit worryingly alongside a national trend for increasing income-related health inequalities, which are perhaps indicative of a widening trend.

Indicator	Middlesbrough	Richmond Upon Thames	England average
Deprivation Score (from least deprived at score of 5.8 to most deprived at 45)	**40.5**	**9.4**	21.7
Children living in absolute low income families	**30%**	**5.2%**	15.3%
Children living in relative low income families	**36.8%**	**6.4%**	18.4%
% of people aged 16-64 in employment	**65.2%**	**82.4%**	76.2%
% of children achieving a good level of school readiness at the end of reception (%)	**63.1%**	**80.6%**	71.8%
Healthy Life expectancy males (years)	**57.8**	**71.9**	63.4
Healthy life expectancy females (years)	**58.5**	**69.7**	63.9
Life expectancy males (years)	**75.4**	**82.6**	79.8
Life expectancy females (years)	**80.3**	**86.3**	83.4
Mortality rate for causes that are preventable (DSR per 100,000 pop)	**245**	**106.6**	100

Table 2.3 high-level comparison of health and socio-economic data between Middlesbrough and Richmond upon Thames

[1] Naik et al, 2020, 'Using economic development to improve health and reduce health inequalities'

2.4 Since 2015, Middlesbrough has been identified as the most deprived area nationally (based on proportion of lower super-output areas within the 10% most deprived). The recent Marmot Review highlighted that previous increases in life expectancy in the area, had worrying declined or stagnated in the last decade. Indeed the previous year-on-year improvements in life expectancy observed in Middlesbrough between 2001-2003 and 2011-2013 were mainly driven by gains in the affluent wards across the town, with the deprived wards showing very small changes in life expectancy in the last 15 years.

2.5 Whilst, some of this has been attributed to reduced social protections brought about by increased government austerity, the association between life expectancy and living standards additionally points to the impacts of the 2008 economic recession and persistent levels of income inequality experience since the 1980s - alongside other complex and interacting factors.

2.6 In the run-up to COVID-19, a national paradox between growth in employment and GDP, in the face of entrenched poverty, low quality jobs and poor income and living conditions, cast a light on the unequal distribution of economic progress. Good health is not however just a product of a thriving economy, it is a necessary contributor to it. A recent LGA report[2], highlighted the cost of poor health on the economy, presenting some of the annual costs experienced nationally as a result, this included:

- Over £100 billion a year in productivity lost due to poor health;
- £42 billion a year in workforce costs attached to mental health issues;
- c£4.8 billion a year costs of socio-economic inequality on the NHS; and
- £15 billion worth of sick days

2.7 COVID-19 will undoubtedly amplify the economic costs outlined above, with early findings from the crisis additionally pointing to the unequal distribution of the direct and indirect impacts of the virus across socioeconomic lines. Higher number of death from COVID-19 in people living in socioeconomically deprived areas[3] were observed from as early as May 2020, with some studies suggesting that people residing in poor areas are over twice as likely to be killed by the virus than those in the richest[4].

2.8 In addition to the above, the control measures enforced to stem the virus have broader implications on income and job security. The IFS suggests that (excluding key workers) the majority of the people in the bottom tenth of earning distributions, correlate to sectors that have been shut down as a result of COVID. When those who are unlikely to work from home are included within this, it is estimated that job security of c80% of low income earners, have been indirectly affected by the pandemic. As key determinants of health, these impacts are likely to have a significant influence in person's ability to live a healthy live and will invariably translate to increased risk of premature mortality and morbidity that extends beyond the immediate risk of the virus.

[2] LGA, 2019, 'Nobody left behind: maximising the health benefits on an inclusive economy'.
[3] https://www.health.org.uk/news-and-comment/blogs/inequalities-and-deaths-involving-covid-19
[4] https://www.kingsfund.org.uk/press/press-releases/covid-19-stark-differences-life-expectancy

2.9 A framework for understanding the relationship between health and the economy has been outlined below, which demonstrates the complex interplay between variable factors that work with and through each other to shape health outcomes (which in turn shape the socioeconomic context).

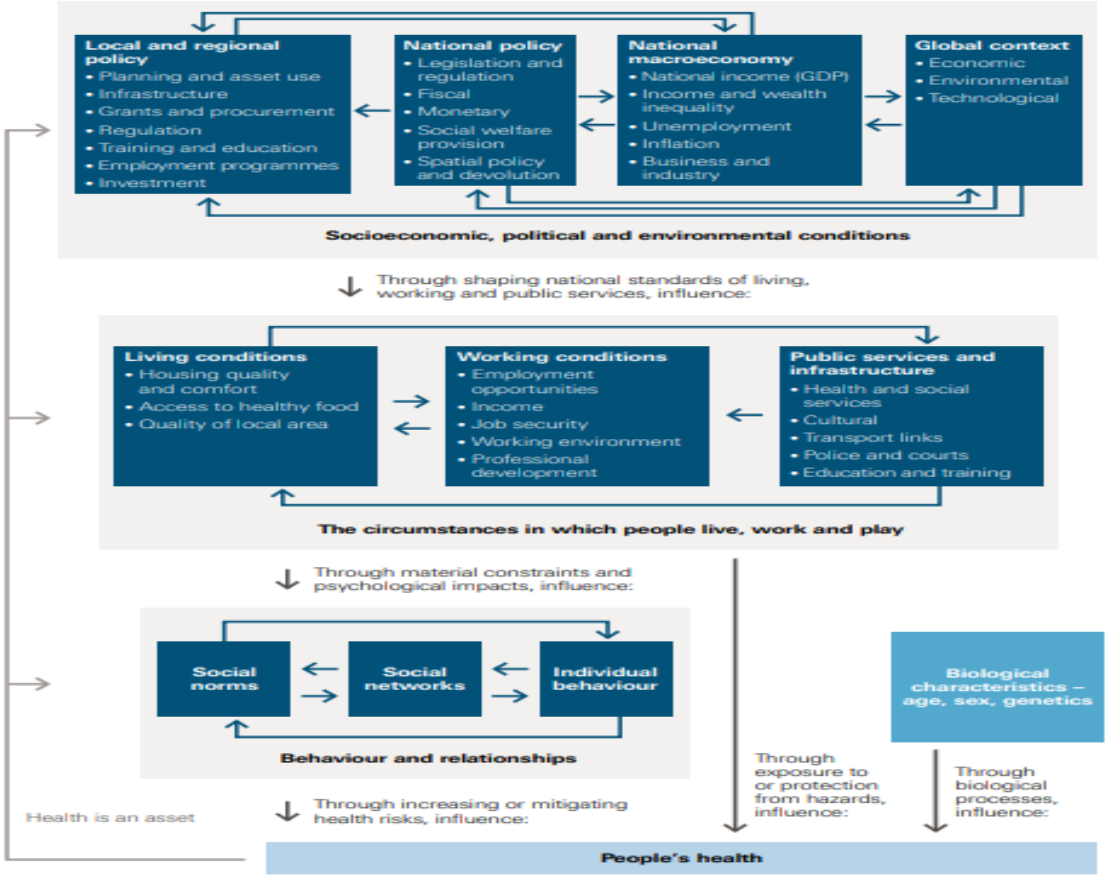

Diagram 2.10, drawn from WHO commission on Social Determinants of Health, 2010

2.10 Whilst the relationship between health and socioeconomic status is highly complex, the above provides a high-level demonstration of the intrinsic link between the two. It also necessitates the prioritisation of inclusive economic strategies in-light of the COVID-19 pandemic, which will undoubtedly by characterised as both a health and economic crisis. As indicated by the LGA - *'there is a danger that inequalities ingrained in the 'old world' will widen, and that those left behind by traditional models of growth will suffer the most from the economic fallout of this global crisis'*.

3.0 Key Local Government Levers

3.1 Councils and Combined Authorities have a significant role to play in developing inclusive economies. By embracing place-based approaches - that acknowledge the collective role of policy, services and communities in maximising the potential for shared prosperity and

growth – shared economic development and public health approaches, can play a critical role in securing a fair and thriving borough.

3.2 6 high-level areas of prioritisation in promoting inclusive economies, have emerged from the evolving evidence base, these have been outlined below and sit alongside a wider call for improved engagement between economic development functions and public health[5]:

- Building a thorough understanding of local issues, to affectively diagnose the challenges and levers to inclusive economic growth and to better understand the impact of growth policies across population groups (e.g. BAME communities);
- Having a long term vision and strong leadership, underpinned by a desire to design local economies that are good for people's health- including rebuilding economies in a way that takes stock of the lessons learnt from COVID-19;
- Building strong citizen engagement to inform priorities and strategies, in a way that builds community momentum and meets local aspirations;
- Capitalising on local assets and using local powers more actively – including harnessing local government powers to shape economic conditions and capitalising on key assets such as, industrial sector, cultural heritage, natural environment and anchor institutions;
- Providing services that meet people's economic and health needs together.

3.3 The imperatives outlined above for improved alignment between health and wealth, provide a critical starting point for prioritising action at the local government level.

4.0 Recommendations

4.1 It is recommended that the Health Scrutiny Board consider the high-level actions outlined in section 3.2 and make recommendations on how these can be explored locally, as a first step in:

- ensuring the Council's ability to shape the conditions for inclusive economies are fully harnessed, and
- identifying ways in which improved alignment can be achieved between strategies to address health and economic development

[5] Naik et al, 2020, 'Using economic development to improve health and reduce health inequalities'