



Health in all policies: health, austerity and welfare reform

A briefing from the board of science

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Summary

Austerity and welfare reform in the UK has resulted in substantial reductions in public spending, principally through budgetary cuts on departments and services. This has significantly affected local government funding and welfare support.

The broad impact has been to hamper progress in reducing inequality and poverty; poorer job prospects (particularly for younger people); a decrease in the number of households achieving a minimum income for healthy living; increases in relative child poverty; and increasing levels of material deprivation. These factors can impact negatively on health and wellbeing in the absence of strong social support systems.

Vulnerable groups have been disproportionately affected, including individuals, families/ children and older people on low incomes, as well as those unable to work because of disability or long-term illness. This has been compounded by substantial cuts to local services, with the more deprived local authorities in the UK being the hardest hit.

While it is too early to assess long-term effects, a range of specific adverse impacts have been reported, including: reduced household income and a consequent inability to keep households warm, increasing the risk of winter mortality and a range of illnesses; increased mortality among pensioners aged 85 and over; deterioration or relapse of existing health conditions; higher rates of individuals neither in receipt of benefit payments nor in or searching for employment; rising levels of food insecurity and poorer diets in low income households; increased prevalence of mental health conditions; and increased rates of homelessness. A notable impact is the significant increase in the male suicide rate in the UK during the recent period of recession.

Robust action is needed to mitigate the adverse impacts of austerity and associated welfare reform, and protect and promote health. This includes a stronger focus on reducing social and economic inequalities (based on the recommendations set out in the Marmot Review), supported by a cross-government action plan.

Evidence and experiences in other countries (such as Iceland, Sweden, Canada and Norway) highlights the importance of maintaining high levels of public spending on social welfare and health as important mechanisms for improving health outcomes and narrowing health inequalities, while also supporting economic growth. This demonstrates the need for:

- increased investment in social protection systems – such as unemployment programmes, housing support and income maintenance – to counter the projected future decrease in welfare spending
- increased investment in healthcare and public health services in the short and long-term, including adequate funding for evidence-based preventative and early intervention services.

To ensure the impact on physical and mental health is accounted for in decision-making, there should be a mandatory requirement for all government departments and public bodies to adopt a 'health in all policies' approach and undertake an assessment of the impact of all new policies and policy changes on health.

There are practical ways doctors can advocate for action in their healthcare setting and community, and by influencing local and national policy. In many cases, getting involved in existing initiatives will be the best approach. The following summarises some suggested practical ideas for action.

Action in the healthcare setting

1. Consider how to improve patients' health literacy.
2. Provide links to non-medical sources of support within the community.
3. Develop local strategies to empower vulnerable groups in accessing health services.

4. Encourage healthcare organisations to assess the impact of policy changes on health.
5. Support development of patient-focused, integrated services and prioritise commissioning of services that promote and maintain health.
6. Encourage a more holistic approach to commissioning and public service policy development.
7. As a GP, get involved with your local medical committee.

Action in the local community

1. Find out how to influence local policy decisions and consider their impact on health.
2. Lobby local authorities to assess the impact of their policy and planning decisions.
3. Consider how you can directly influence decisions (eg as a local councillor).
4. Get involved in local community projects and networks.

Influencing national and international policy

1. Consider what health-based arguments should be made to policy makers.
2. Encourage and get involved in action by professional associations and bodies.
3. Get involved in a health-based network or share experiences with health organisations.
4. Write to local councillors and/or relevant elected representatives.

1 Introduction

Doctors are concerned^a about the impact of austerity and associated welfare reform on health and wellbeing, and believe governments need to do more to protect the most vulnerable and disadvantaged in society who suffer a disproportionate burden. They witness first-hand the detrimental effects on their patients' health and wellbeing, but are unable to directly address the contributory factors that are beyond their clinical influence. These factors are linked to a range of economic and social policies that affect wellbeing and welfare, social security, employment, families and communities, health and social care, pensions, living conditions, social housing, and education. Doctors therefore have a vital advocacy role to ensure that the health needs of their patients and the wider population are readily considered across all these policy areas.

"Austerity is the central public health issue of our time. From A&E departments to mental health to child health, austerity hampers the ability of the NHS to respond to the needs of the British population...and austerity falls hardest on the poorest in society, the most vulnerable, the voiceless."

Dr Yannis Gourtsoyannis, infectious disease registrar, University College London Hospitals

This briefing aims to support this advocacy role by providing an overview of the evidence on the relationships between austerity, welfare reform and health, and how these link to the social determinants of health. It also considers what action is needed to protect and promote health during and after periods of financial crisis. While this predominantly has an emphasis on advocating for national action and policy, it also highlights ways doctors can take direct action.

1.1 Background

The economic approach of austerity, and its association with health and wellbeing, has become increasingly prominent in recent years. While government spending has increased year on year in absolute terms since the start of the recession, in real terms it has been static or falling since 2009.¹ The effects have not been felt evenly, with certain government departments and services receiving 'ring-fenced' budgets. In England, this includes the education and health budgets. This has placed the burden disproportionately on other services. Some of the largest budgetary reductions between 2010 and 2015 were for the Department for Communities and Local Government, and consequentially for the funding for local authorities in England derived from central government.² This is particularly significant for health outcomes due to the range of services provided by local councils that impact on health and wellbeing.

In 2010, the Coalition Government committed to ring-fence the NHS budget in England.³ A 2015 assessment by The King's Fund suggested that it met 'the spirit' of this promise across the parliamentary period.⁴ However, the BMA has raised significant concern about funding for the NHS in England during this current parliamentary term (see **Figure 1**).⁵

It is also important to note that health and wellbeing are determined by factors beyond the NHS. Local government budgets decreased significantly between 2009-10 and 2014-15, with spending per person reduced by 23.4% on average.⁶ This affected the services provided by local councils, including adult and child social services. Cuts to other services, such as the police and public libraries, are also worthy of note, given their role in supporting communities and protecting vulnerable individuals.

^a The BMA has passed several resolutions at successive annual representative meetings highlighting doctors' concerns about the impact of austerity and welfare reform on health. This concern was also a key theme emerging from the special representative meeting held on 3 May 2016.

Figure 1 – mismatch in NHS funding and efficiency savings in England

The Five Year Forward View⁷ estimates that the NHS in England is heading for a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. It suggested that to close the gap, the NHS needs to achieve efficiency gains of 2-3% each year combined with staged funding increases close to flat real term NHS spending per person (ie that takes account of population growth). This has been interpreted as a funding increase of £8 billion and annual efficiency savings of £22 billion.

Analysis by the BMA has found that total health spending in England will rise by only £4.5 billion in real terms between 2015/16 and 2020/21, an average annual increase of 0.9%.⁵ This reflects that spending outside of NHS England's budget – including public health (see section 3.2), education and training, capital spend and national bodies such as NICE (National Institute for Health and Care Excellence) – is being cut by more than £3 billion.

The decision of the UK Government to reduce its budgets also has implications for the spending of the devolved administrations in Scotland, Wales and Northern Ireland. Through the Barnett formula (which is based on population size rather than need), changes to departmental budgets in Westminster are automatically applied to the grants for the devolved administrations and adjusted to take into account the proportion of activity in that department that is devolved.

The devolved administrations may therefore have some degree of austerity imposed on them due to a lower allocation, although this may be reduced relative to that in England. It is then for the devolved administration to determine whether to protect or cut a particular area. For instance, in Scotland, the NHS budget has been cut by 1% in real terms between 2009/10 and 2015/16, but local government budget cuts were less severe than in England.⁸ In Wales, funding for the NHS fell by an average of 2.5% a year in real terms between 2010/11 and 2012/13.⁹ This was followed by an increase in 2013/14, but funding is likely to continue to fall until 2015/16, when the total budget for the Welsh NHS is projected to be 3.6% lower in real terms than it was in 2010/11.⁹ The Nuffield Trust estimate that there will be a funding gap of £2.5 billion for the NHS in Wales by 2025/26, which will require further efficiency savings worth 3.7% a year in real terms after 2015/16.⁹

Terminology

Austerity

There is contention around the definition of austerity. Broadly, it is applied to the actions taken by a government with the stated aim of reducing the budget deficit, which in the UK stood at 10.2% of GDP (gross domestic product) in 2009/10.¹⁰ Austerity can be considered, in the simplest terms, as an attempt to reduce government spending through budget cuts. This is often expanded to take into account measures to increase taxation.¹¹ An alternative definition of austerity is growth in budgets below what would be expected, or where a budget is frozen but not cut. Added complications arise when considering structural deficits; the deficit once the state of the economy has been taken into account.¹²

While there is debate about the precise definition of austerity, and indeed in some cases whether it has even taken place in the UK, the common theme between all attempts to define austerity is the pressure on budgets. **For the purposes of this briefing, austerity is considered as the process of reducing public spending principally through budgetary restrictions on departments and services.**

Welfare reform

The impact of welfare reform is a complex issue. A number of changes have been made in recent years that differ across the UK. The UK Government's reforms – such as the withdrawal of the spare room subsidy^{13,b} (commonly referred to as the 'bedroom tax'), the introduction of universal credit and a welfare cap¹⁴ – all apply to England and Wales. The Scottish Government voted to end the bedroom tax in 2014, but remains affected by the cap and the rollout of universal credit. Northern Ireland has not currently implemented any of these measures, but an agreement has now been reached for the roll-out of a package of welfare reforms.

A range of benefits sanctions has been introduced to provide greater conditionality into welfare, affecting all parts of the UK. If recipients do not attend meetings at job centres, apply for jobs or take jobs offered to them, they can have their Jobseeker's Allowance payments suspended for varying periods of time, depending on the particular circumstances.¹⁵ ESA (Employment and Support Allowance) payments could be reduced until recipients meet compliance conditions, such as taking part in a work-focused interview.¹⁶ Over the last few years, more severe and lengthier sanctions have been implemented, and the rate of sanctions has increased substantially in the last five years.¹⁷ There has also been concern expressed about whether the sanctions have been fairly and proportionately applied.^{18,19}

b In January 2016, the Court of Appeal ruled that this policy amounted to unlawful discrimination in two cases (related to a victim of extreme domestic violence and grandparents of a severely disabled teenager). The Department for Work and Pensions is planning to appeal against the ruling.

2 Impact on health and wellbeing

An individual's health and wellbeing is shaped by a range of economic and social influences, including material circumstances, behaviours and the social environment (commonly referred to as the 'social determinants of health').^{20,21} These are in turn affected by factors such as income, employment and working conditions, housing and neighbourhood conditions, and standards of living. Pressure on these factors resulting from reductions in public spending, and associated welfare reforms, can have a detrimental impact on health and wellbeing. This will have a cumulative impact, where the impact of changes to welfare policies are compounded by cuts to social protection systems. While this impacts across the social gradient in health, as the Marmot Review highlighted, there is a disproportionate burden on those with greater social and economic disadvantage.²⁰ The impact of a whole range of factors also follows the social gradient – for example, the Troubles associated with the constitutional status of Northern Ireland during the latter half of the 20th century were found to disproportionately affect people in poorer households, and have had enduring legacy across issues of economic development, poverty and social exclusion.²²

2.1 Overall impact

Various global organisations have considered the broader health and social impact of the financial crisis.^{23,24} A 2014 OECD (Organisation for Economic Co-Operation and Development) report noted that the financial upheaval and subsequent fiscal consolidation hampered progress in reducing inequality and poverty; created a social crisis with knock-on effects on people's job prospects, incomes and living arrangements; increased the numbers living in households without any income from work; and would lead to long-term impacts on family formation, fertility rate and health.²³ Specifically in relation to the UK, the OECD report highlighted that:

- as a country where social spending is mainly to support low-income groups, cuts to this spending would be much more likely to widen income inequalities;
- the number of young people aged 15-16 to 24 who were NEET (not in employment, education nor training) increased since the onset of the economic crisis (by 1.9 percentage points between 2007 and 2012);
- the NEET rates for the 15 to 29 age group in 2011 were significantly higher for people with low education levels (24.0%) than for those with higher education levels (8.4%), compared to the average across OECD countries (15.8% and 13.3% respectively).²³

A 2014 UNICEF (United Nations Children's Emergency Fund) report highlighted a strong and multifaceted relationship between the impact of the recent period of recession on national economies and a decline in children's well-being since 2008.²⁴ It reported:

- an increase in child poverty in the UK (by 1.6 percentage points) between 2008 and 2012 (calculated using a poverty line fixed at 60% of median income), with the UK performing poorly in changes in child poverty over this period compared to other EU (European Union) and/or OECD countries (ranked 25 out of 41 countries);
- a sharp fall in median income in households with children in the UK (of almost 15%) between 2007 and 2012;
- an unprecedented increase in the number of children (aged 17 and under) living in severe material deprivation,^c to the extent that the UK accounted for 14% of all the children living in such households across the 30 European countries analysed in 2012.²⁴

Several reviews have considered the impact of the financial crisis on health and health care across Europe.^{25,26,27} These have found adverse outcomes in a range of health indicators,

c Where a child lives in a household that cannot afford at least four of the following nine items: 1) to pay rent, mortgage or utilities; 2) to keep the home adequately warm; 3) to face unexpected expenses; 4) to eat meat or proteins regularly; 5) to take a holiday; 6) to have a television; 7) to have a washing machine; 8) to have a car; 9) to have a telephone.

including short-term impacts such as increased rates of mental health problems and suicides (see section 2.6), and higher prevalence of communicable diseases.

Following a narrowing in health inequalities in England between the periods 1999-2003 and 2006-10,²⁸ the IHE (Institute of Health Equity) has reported a subsequent widening since austerity policies were first implemented.²⁹ In Scotland, the gap in prevalence of below average mental wellbeing between those in the most deprived areas and least deprived areas widened between 2008/2009 and 2012/2013.³⁰ In Northern Ireland, the gap between healthy life expectancy in the most and least deprived areas increased for women between 2010-12 and 2011-13, with no change for men.³¹ In Wales, the most recent available data cover the period 2008-12, providing less insight into the effects of the period of austerity policies. However, these show a slight increase in healthy life expectancy.³²

The Marmot Indicators 2015 have revealed that the percentage of households in England not achieving a 'minimum income for a healthy living'^d has increased year on year, from 19.1% in 2008/09 to just under a quarter (24.4%) in 2012/13. Comparable data on the minimum income for healthy living are not available in Scotland, Wales or Northern Ireland.

Analysis by the IFS (Institute for Fiscal Studies) has found that income inequality in the UK is lower than before the recession due to a combination of rising employment, falling earnings and some increases in benefit income (between 2007/08 and 2009/10).³³ However, the Institute has projected that this fall in inequality is likely to be undone over the next five years as a result of further benefit cuts at the bottom of the income distribution, and a predicted rise in real earnings among middle and upper parts of the income distribution. When considering different age groups, their analysis found that tax and benefit changes:

- had little effect on pensioners and much bigger effects on those of working age, especially those with children;
- resulted in significant losses for those of working age in the bottom half of the income distribution;
- had limited impact on the income, on average, for those from the middle of the income distribution.

Looking forward, their analysis projects that pensioners will be less affected (as a result of continued protection of pensioner benefits), while poorer working age households will be hit hardest, especially those with children. Households in the upper half of the income distribution (but below the very top) are likely to see little direct impact of tax and benefit changes on their incomes on average.

While it is too early to assess the long-term impact of austerity policies on health and wellbeing in the UK, the data highlighted in the preceding paragraphs show a broad range of negative indicators of significant concern. These factors can impact negatively on health and wellbeing in the absence of strong social support systems. Pressure on incomes, job security, employment opportunities and living arrangements are all likely to shape people's lives in the long term, and continue to contribute to poorer health and wellbeing outcomes. As the OECD notes, this is a particularly concerning feature of the prospects for the next generation: '[a]n obvious and much-discussed impact is "scarring", or the danger that young people who suffer long periods of unemployment, inactivity or poverty face a lifetime of diminished earnings and weakened job opportunities.'²³

"It is government policy to increase inequality, and to make things harder for families with children. And that will have an adverse impact on the health of the children, the health of those children when they become adults, and the health of the parents who are trying to make ends meet."

Professor Sir Michael Marmot, former BMA President, speaking at the 2016 BMA Special Representative Meeting.

^d The level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care, and hygiene.

2.2 The groups most disadvantaged by welfare reform

Welfare payments are a vital support mechanism for vulnerable groups, such as individuals, families/children and older people on low incomes, as well as those unable to work because of a disability (particularly learning disabilities) or long-term illness. Concern has been raised by charity and support organisations that these groups will suffer significantly because of the broad approach taken to welfare reform.^{34,35,36,37}

While evidence of the direct impact of austerity policies and the current programme of welfare reform on these groups is limited, it is reasonable to suggest that any measure, or combination of measures, that reduces their income will negatively impact on health. For example, the inability of low income households to keep warm (fuel poverty) can increase the risk of winter mortality;³⁸ and cold homes are linked to higher levels of respiratory conditions,³⁹ poor mental health,⁴⁰ and higher rates of cardiovascular disease.^{41,42} In 2013, 17% of UK households were affected by fuel poverty, and of the four UK nations, Northern Ireland^e has the greatest proportion of fuel poor households.⁴³ Insufficient income can also impact on health through food insecurity (see section 2.4) and increased risk of mental illness (see section 2.6).

“Vitaly important welfare to work strategies are being discredited in the country at the moment, because welfare to work now means a cruel policy of stigmatising people.”

Dr Stephen Watkins, Director of Public Health

Children born into poverty have an increased risk of mortality in the first year of life and in adulthood, and are more likely to be affected by low birthweight and have increased morbidity in later life.⁴⁴ Analysis by the IFS has projected that relative child poverty in the UK will increase between 2012-13 and 2020-21; initially quite sharply because of changes to the benefit system being introduced, and then more slowly as universal credit is phased in.⁴⁵ The increases are projected to be particularly large in Northern Ireland where employment growth is forecast to be relatively weak, and because changes to taxes and benefits will have a greater impact than in Great Britain.⁴² Mencap has warned that people with learning disabilities are particularly struggling with assessment processes for new welfare systems, and that there is no evidence the reforms are helping reduce the disproportionately high number of people with a learning disability who are unemployed.^{46,47}

A recent parliamentary inquiry⁴⁸ expressed the following concerns about the impact of welfare reforms on children.

- The changes to the statutory mechanism for tackling child poverty set out in the Child Poverty Act 2010 that place greater emphasis on worklessness and low educational attainment would not capture the substantial number of children in poverty that live in working households.
- The combined effect of lowering the benefits cap, four year benefits freeze and changes to the universal credit work allowance would significantly reduce the income of thousands of already struggling families, particularly those with a single parent. This would increase levels of child poverty and exacerbate the many risks to children’s health, wellbeing, educational development and future prospects.
- The introduction of greater conditionality for carers in universal credit (lowering the age of the youngest child of a carer at which the carer is expected to begin work-related activity) will exacerbate child poverty as many carers, particularly single parents, are highly motivated to find work but face significant structural barriers to employment.
- There is strong evidence that the cumulative effect of the welfare reforms are likely to increase levels of child poverty for those households affected by them. Families with one or more disabled member including disabled children; lone parents; families at risk of homelessness; families with three or more children; and other vulnerable groups will be most affected.

^e Northern Ireland has a higher proportion of fuel poor than other nations due to a high percentage of off gas grid households (who rely on more expensive fuels such as heating oils) and lower income households.

There is some emerging evidence of the direct impact of the current programme of welfare reform on old-age adults^f on low incomes, and individuals with existing long-term health conditions. A 2016 longitudinal study found that reductions in Pension Credit spending and social care were linked to rising mortality rates among pensioners aged 85 years and over.⁴⁹ A 2015 online survey of 1,780 individuals across the UK with multiple sclerosis found that the move towards greater conditionality in the welfare system had caused their condition to deteriorate or relapse (reported by 48% of respondents in relation to ESA and 36% in relation to the PIP (Personal Independence Payment) assessment.⁵⁰ There is also limited evidence suggesting that the increasingly stringent sanctions linking unemployment benefits with welfare conditionalities have resulted in higher rates of disconnection from welfare and work (ie being neither in receipt of benefit payments nor in or searching for employment).⁵¹

What is the impact of the July 2015 budget?^{52,53}

The UK Government's budget, announced in July 2015, included welfare cuts of £13 billion a year by 2020-21, with a freeze to working age benefits and tax credits for four years from 2016/17 being the largest cut. This is predicted to affect 13 million families across the UK, losing £260 a year on average (with 7.4 million of these in work, losing £280 a year on average). Reduced income thresholds in tax credits and work allowances in universal credit will affect around 3 million families in the UK, who will lose approximately £1,000 a year on average.

Analysis of the impact of tax and benefit reforms between April 2015 and April 2019 (including universal credit) suggest that there is a disproportionate impact on low income households. Those in the poorest income groups will lose around 7% of net income on average, compared to a negligible loss on average for the richest income group and an average loss for all households of around 1.5% of net income. Many of the working families affected by the tax credit cuts will not be compensated by the higher minimum wage, and unequivocally on average, tax credit recipients in work will be made worse off by the measures in budget.

2.3 The effect of budget cuts on local services

Local authorities are responsible for providing a range of services, such as adult and child social services, and in England, public health services. The cuts to local government have been among the most severe during the deficit reduction programme.²

The impacts of the cuts have been felt disproportionately in certain areas of the UK. A 2015 Joseph Rowntree Foundation report noted that the ability of local councils in England and Scotland to influence health and well-being is limited as austerity is hitting councils in the poorest regions the hardest.⁵⁴ These areas are also those seeing the greatest financial losses as a result of welfare reform.

"We are starting to see a perfect storm – the government in England shifts responsibility for providing services from the centre to the local level, and then cuts the funding for local authorities."

Dr Iain Kennedy, BMA public health medicine committee chair

Other reports have come to the same conclusion, while noting that these areas also often have a higher demand for services.⁵⁵ The Due North report – the outcome of an independent inquiry commissioned by PHE (Public Health England) to explore actions to tackle health inequalities in the north of England – identified that the main causes of health inequality are more severe in the north of England than elsewhere in the country.⁵⁶ According to analysis by Sheffield Hallam University, the financial impact of the welfare reforms varies greatly across the country, where, as a general rule, the more deprived

^f The board of science will be publishing a series of briefing papers on the medical and social care of older people in autumn 2016 as a part of a project on 'Growing older in the UK'.

the local authority, the greater the financial hit.^{57,58} The worst-hit areas have typically experienced losses two and a half to three times higher per adult of working age, as the areas least affected by the reforms. This includes the older industrial areas of England, Scotland and Wales; a number of seaside towns; and some London boroughs (see **Figure 2**).

Figure 2 – estimated financial loss arising from welfare reform by March 2016

Loss per working age adult (£ p.a.)			
Top 10 districts		Bottom 10 districts	
Blackpool	720	South Oxfordshire	220
Westminster	680	Winchester	220
Knowsley	560	South Northamptonshire	220
Brent	550	Wokingham	210
Middlesbrough	550	Aberdeenshire	210
Hastings	540	Guildford	210
Barking and Dagenham	540	Hart	210
Torbay	530	Aberdeen	210
Enfield	530	Shetland	200
Hartlepool	520	Cambridge	190

Source: Beatty C & Fothergill S (2016) *The uneven impact of welfare reform. The financial losses to places and people*. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University.

Protecting the poorest from budget cuts has become increasingly challenging. Around 62% of local councils' expenditure is spent on services used more by the poorest, including adult and children's social care, homecare, homelessness and public transport.⁵¹ The Joseph Rowntree Foundation suggested that councils have been 'coping' with cuts to date and trying to protect the poorest, with cuts falling disproportionately on services used by wealthier local residents. However, it believes that cracks are now starting to show.⁵¹ In England, it is worth noting that changes (made in 2013) to the funding distribution for local authorities differentially affected the spending power of different authorities, with less deprived authorities, on average, seeing a slightly smaller fall in spending power than more deprived authorities.⁵⁹ This reflects that the revised funding allocation system explicitly does not factor in differences and changes in local need.

The impact on mental health has been highlighted as a particular concern (see section 2.6), while services for children and people with learning disabilities have been among the worst affected by the cuts. For example, one in three local authorities in England have closed day services for adults with learning disabilities,⁶⁰ and Liverpool is set to cut the number of children's centres from 27 to three, with reductions also announced in Sheffield and Rotherham.⁵³

Cuts to other services are predicted to have an impact on health and wellbeing. For example, police services regularly come in contact with individuals affected by domestic and other forms of violence, as well as people with mental health problems. As highlighted by the APCC (Association of Police and Crime Commissioners), which represents police and crime commissioners in England and Wales, the ability of the police to respond comprehensively to the needs of these groups will be challenged by budget restrictions and contraction of the service.⁶¹ Substantial cuts to Citizens Advice services have also been reported as leaving thousands of people without any support in resolving urgent and serious problems.^{62,63,64,65,66,67} Similarly, the role of public libraries in providing accessible community support is threatened by funding constraints and closures.⁶⁸

Local authority funding for the voluntary sector fell sharply at the start of the economic crisis in 2008, and despite an increase in 2013/14, local government funding to the sector is £475 million less than in 2009/10.⁶⁹ This has adversely affected the ability of third sector organisations to support vulnerable groups. Charity organisations now typically have to compete for reduced levels of funding that are inadequate to maintain the same level of staffing or quality of care; this in turn has seen charities reduce or withdraw services that are not provided elsewhere, and many have closed.

2.4 Increasing levels of food insecurity

There has been an unprecedented increase in the use of food banks in the UK since the recession and the start of austerity policies,⁷⁰ indicating that more people are likely to suffer from food insecurity. This is particularly concerning as the increased use of food banks correlates strongly with increased hospital admissions for malnutrition.⁷¹

Research has suggested that austerity is driving the use of food banks. Data from a 2015 observational study of the Trussell Trust's records on food bank use from 2009 onwards found that the rise in use was associated with cuts to local authority spending and central welfare spending, and that the highest levels of use occurred where there have been the highest rates of sanctioning, unemployment, and cuts in central welfare spending.⁶⁶

According to a joint report by Oxfam, Church Action on Poverty and the Trussell Trust, there are a range of factors causing increased food bank use in the UK, such as persistent low wages, changes to council tax support and the cumulative effects of changes to housing benefit and the spare room subsidy.⁷² Similar findings are reflected in a 2014 evidence review for the All-Party Parliamentary Inquiry into Hunger in the United Kingdom.⁷³ This noted that long-term trends in the prices of food, fuel and housing has exposed low-income households to the likelihood of hunger and food poverty. As highlighted in the 2015 board of science report, *Food for thought: promoting healthy diets among children and young people*, this makes it particularly challenging for the poorest households to eat healthily.⁷⁴ This reflects how foods that are more nutrient dense per calorie (lean meat, fish and fruits and vegetables) are more expensive.^{75,76,77}

2.5 The association between employment and health

There is a wide body of evidence that being in 'good work'^g has a beneficial impact on an individual's health and wellbeing.^{20,78,79,80} Where a job is insecure, low-paid or fails to protect against stress and danger, it can be a significant cause of ill health.²⁰ Unemployment, particularly long-term unemployment, increases the risk of physical ill health (notably cardiovascular disease),^{81,82} mental illness,⁸³ and premature mortality.⁸⁴ A 2015 analysis by The King's Fund found that employment deprivation – the percentage of people who are involuntarily unemployed – was particularly important for persistently low life expectancy.⁸⁵ A 2009 empirical analysis – looking at how economic changes have affected mortality rates over the past three decades – found that rises in unemployment are associated with significant short-term increases in premature deaths from intentional violence, while reducing traffic fatalities.⁸⁶ A 2016 longitudinal analysis found that unemployment increases are associated with rises in cancer mortality, and estimated that the 2008-10 economic crisis was associated with approximately 260,000 excess deaths in the OECD area.⁸⁷

g Features of good work include: stability and job security, adequate safety measures and standards of employment; ability to exert some control about the place and the timing of work and tasks to be accomplished; placing appropriate demands without overtaxing resources and capabilities or doing harm to physical and mental health; providing fair employment in terms of earnings; providing opportunities for skill training, learning and promotion; protecting against social isolation and any form of discrimination and violence; providing the ability to participate in organisational decision-making; reconciling work and extra-work/family demands; supporting reintegration of sick and disabled people into full employment wherever possible; and contributing to workers' well-being.

When considering the impact of austerity, the relationship between employment and health becomes increasingly important in the context of the changes in public and private sector employment since 2008. This latter aspect was examined in a 2015 briefing by SPERI (the Sheffield Political Economy Research Institute).⁸⁸ Overall, this found that public sector job losses and the growth in private sector jobs have been spread very unevenly across the UK.

Specifically:

- there was a 10.7% reduction in public sector jobs between the first quarter of 2008 and third quarter of 2014 in the UK;
- while only 3.1% of public sector jobs were lost in London, the rate was much higher in the North East of England (19%), the West Midlands (12.4%), Yorkshire (12.6%), Wales (9.5%) and Scotland (9.1%);
- during the same period, the size of the private sector in London increased by 15.7%, compared to much more sluggish growth in Yorkshire and the Humber (7.8%), the West Midlands (5.7%), Scotland (4.3%) and Wales (1.1%).⁸⁴

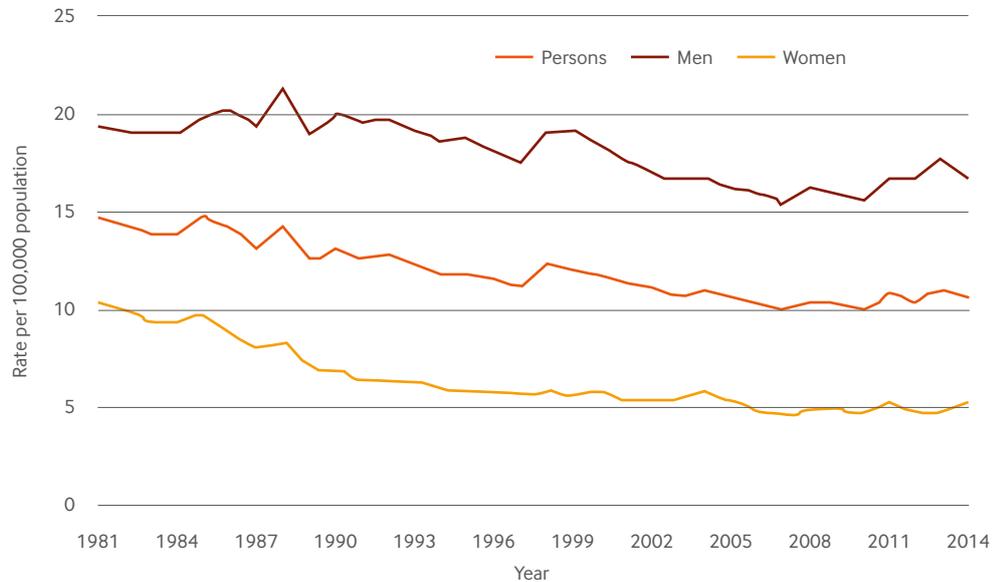
Northern Ireland is particularly dependent on central government spending and public sector employment, with 25.2% of the population employed by this sector, compared to 16.0% for the UK as a whole.⁸⁹ While it has seen an increase in private sector employment, the overall employment rate remains lower in Northern Ireland than elsewhere in the UK,⁹⁰ and the rate of economic inactivity (26.4%) is significantly higher than in the UK (21.6%).⁹¹ This is compounded by the fact that the public sector accounts for approximately 70% of the country's GDP. This makes Northern Ireland particularly vulnerable to future cuts in public spending and reductions in public sector jobs.⁹²

2.6 Austerity, mental health and suicide

Mental health problems are more common in areas of deprivation and poor mental health has been consistently associated with low income and debt.⁹³ There are a number of factors that may exacerbate financial pressures that are associated with austerity and welfare reform. These include: changes to council tax exemptions, a rise in interest rates and the introduction of a new benefits system. For example, a 2016 observational study found that a reduction in housing support to low-income persons in the private rental sector increased the prevalence of depressive symptoms.⁹⁴ In a letter to the Guardian in 2015, 442 psychotherapists, counsellors and academics expressed concern about the psychological effect of cuts and their effect on quality-of-life.⁹⁵ They highlighted a shift in the causes of distress, towards that caused by poverty and inequality, families being forced to move, and the subjecting of benefits claimants and jobseekers to greater conditionality in receiving welfare payments.

A 2016 systematic narrative review of the health effects of the economic crisis in high-income (OECD) countries found that the most widely studied and consistent adverse impact of the crisis was on mental health (including a rise in depression and suicides).⁹⁶ Data from the ONS (Office for National Statistics) show a temporal association between the rates of suicide in the UK and the recent period of recession – after a downward trend between 1981 and 2007 (decreasing from 14.7 to 10.0 deaths per 100,000 population), rates began to increase in 2008, peaking at 11.1 deaths per 100,000 in 2013, before dropping slightly in 2014 to 10.8 deaths per 100,000 (see **Figure 3**).⁹⁷ The suicide rate was significantly higher among men – since 2007, the female suicide rate has stayed relatively constant and was 5.2 deaths per 100,000 in 2014; in comparison, the male rate increased significantly between 2007 and 2013, peaking at 17.8 deaths per 100,000 population in 2013, before falling to 16.8 deaths per 100,000 in 2014.⁹³ Considering this association in more detail, a time-trend analysis – of the actual number of suicides in England between 2008 and 2010 with those that would be expected if pre-recession trends had continued – found there to be approximately 1,000 excess suicides during this period.⁹⁸ Similar trends in suicide rates are seen internationally, particularly in the countries that have implemented the most severe austerity programmes, such as Greece.⁹⁹

Figure 3: Age-standardised suicide rates in the UK by sex, deaths registered between 1981 and 2014



A focus on mental health services

The BMA and other organisations have highlighted concern about the chronic underinvestment in and financial pressures on the provision of adequate mental health services.^{100,101,102} Despite the commitment to achieve parity between mental and physical health, data suggest that mental health services suffered funding cuts in recent years. Research by Community Care and BBC News found that mental health funding in England fell by 8.25% over the course of the last parliament.¹⁰³ Funding for mental health services for children and young people continues to be particularly stretched. According to YoungMinds, in England:

- 75% of mental health trusts froze/cut their budgets between 2013/14 and 2014/15;
- 67% of CCGs (clinical commissioning groups) froze/cut their budgets between 2013/14 and 2014/15;
- 65% of local authorities froze/cut their budgets between 2013/14 and 2014/15;
- over one in five local authorities froze/cut their CAMHS (child and adolescent mental health services) budgets every year since 2010.¹⁰⁴

The recently announced increased investment of £1 billion a year additional funding for mental health services in England by 2020/21¹⁰⁵ is a welcome development; this includes funding for evidence-based psychological therapies, CAMHS, crisis resolution teams, mental health liaison services in emergency departments and inpatient wards, and specialist mental health care in the perinatal period. However, the BMA has highlighted concerns about whether this is new or redistributed funding and how it will be distributed, and also noted that the repeated cuts to public health budgets, and continued pressures on social care, cast doubts on the ability to support mental health before it reaches crisis point.⁵

2.7 Homelessness

There is limited evidence suggesting that welfare reforms and spending changes since 2010 have increased the rate of homelessness.¹⁰⁶ A 2015 observational study – evaluating local authority data in England (2004-12) – found that every 10% fall in economic activity was associated with an increase of 0.45 homelessness claims per 1,000 households, and that increasing rates of homelessness were strongly linked with government reductions in welfare spending (in particular spending on social care, housing services, discretionary housing payments and income support for older persons).¹⁰² Individuals who are already homeless are also very vulnerable. A report for the homelessness charity Crisis raised concerns that homeless people are disproportionately affected by benefits sanctions.¹⁷ This vulnerable group is more likely to be in the most sanctioned demographic – young and male – and more likely to face barriers to complying with their benefits programme.¹⁷ Homelessness can significantly impact on health, making suicide 35 times more likely among homeless people, and cancer twice as likely.¹⁰⁷

3 Promoting and protecting health in a time of financial crisis

While the previous section highlights the evidence of harm to health and wellbeing associated with austerity, this section sets out key policies developed by the BMA on what action is needed to protect and promote health. A key overarching goal is to implement universal actions that tackle the underlying causes of health inequalities, as set out in the Marmot Review. As the Review notes, these normative actions are a matter of social justice, as the existence of such inequalities is unfair when it can be reasonably avoided.²⁰

In a time of financial crisis, there is also a need to recognise the importance of investing to protect and promote health that supports action to reduce inequalities, and ensure that the development and implementation of all policies considers their impact on health.

3.1 National action to reduce social and economic inequalities

The Marmot Review stressed that reducing the social gradient in health requires universal actions '...but with a scale and intensity proportionate to the level of disadvantage.'²⁰

It found that conditions in early childhood are particularly important, and can have a lifelong influence on health.

Recognising that disadvantage starts before birth and accumulates throughout life, the Review recommended that action to reduce health inequalities must take a life course approach by:

- giving every child the best start in life – reducing inequality in early development and ensuring high quality maternity and parenting services;
- enabling all children, young people and adults to maximise their capabilities and have control over their lives – reducing the social gradient in skills and qualifications;
- creating fair employment and good work for all – improving access to good jobs and reducing long-term unemployment;
- ensuring a healthy standard of living for all – establishing a minimum income for healthy living and reducing the 'cliff-edges' between benefits and work;
- creating and developing healthy and sustainable places and communities – such as tackling social isolation;
- strengthening the role and impact of ill health prevention – prioritising prevention and early detection of those conditions most strongly related to health inequalities.

The BMA supports the approach recommended by the Marmot Review, and believes that a cross-government national action plan is required setting out short, medium and long-term actions against each of its recommendations. This should incorporate a framework of monitoring, reviewing and remedying processes, and should be led by the respective UK health departments. The overarching focus of national policy should be to address how mainstream spending is utilised to reduce health inequalities, rather than relying on new project funding streams. An integrated policy framework is needed to ensure all services and action areas are focused on reducing health inequalities.

A focus on child health

The Marmot Review prioritised action to support early years' development, emphasising the need to ensure health and wellbeing is supported at each stage, from pre-conception through to adolescence.²⁰ The Review particularly focused on the way in which education and parenting can be modified to improve long-term health outcomes, where educational interventions and family support offer the best means yet identified of protecting children from inequality and protecting their health.

This approach was endorsed by the BMA in the 2013 board of science report, *Growing up in the UK: ensuring a healthy future for our children*. This report explores how the foundations of health are laid during pregnancy, infancy and childhood, and makes recommendations for reducing inequality in child health.¹⁰⁸ It strongly advocates the importance of prevention and early intervention services, highlighting the negative effects on child health of cuts in the provision of these services. It argues that it is short-sighted to remove funding from prevention, as early intervention costs much less than dealing with the consequences of ill health later in a person's life.

Key recommendations from the report relevant to reducing health inequalities and improving child health include:

- **ensuring research into methods to reduce the impact of social inequalities on child health and wellbeing continues;**
- **investment in the development and maintenance of parenting and early intervention programmes, for example Sure Start children's centres;**
- **improving the quality of housing; making health and wellbeing a priority within housing policy;**
- **recognising and protecting a minimum income required to maintain healthy living, especially in relation to benefit reform;**
- **encouraging partnerships between community, family and educational support schemes.**

The report recognises that tackling the complex social and economic determinants of child health requires a multidimensional policy response across different government departments, and recommends accountability for child health and wellbeing at Ministerial level. It also makes a number of specific recommendations for improving the care of children with a disability, including:

- **increasing awareness of the impact of benefit cuts on families with disabled children;**
- **developing local service partnerships for disabled children;**
- **improving the evaluation of outcome measures for childhood disability.**

A lack of monitoring of access to child health services, and how this is being affected by austerity, could lead to many children receiving inadequate care and support. **It is essential that coordinated initiatives are implemented to monitor the impact that austerity measures and funding cuts have on access to children's health services, especially access to disability services.**

In 2015-2016, the BMA has built on its commitment to improve the health and wellbeing of children and young people by establishing a child health project. The project has three main aims:

- to highlight the disproportionate impact of austerity on children and families;
- to assess the progress made since *Growing up in the UK: ensuring a health future for our children* was published in 2013; and
- to share information and collaborate within the BMA and with other organisations and experts in child health.

A key element of the project has been to host a number of UK-wide events examining the topic of child health inequalities in Belfast, Cardiff, Edinburgh and London. The *Growing up in the UK Roundtable* event in London improved collaboration and engagement between child health organisations and the BMA, including the project partner, the Royal College of Paediatrics and Child Health. Forty representatives from within the BMA and key external health stakeholders attended the event, including the Institute of Child Health, Royal College of Nursing, NSPCC, and The Children's Society. Attendees participated in a collaborative workshop to explore the barriers to positive child health outcomes, and identify how doctors and other health professionals could work in partnership to better meet the health needs of children and young people at their local levels.

Alongside this briefing, the BMA is publishing some complementary research on the effects of austerity and welfare reform on children and families in the UK, as well as some reports on what progress has been made since *Growing Up in the UK* was published in 2013.

3.2 Investing to protect and promote health

Higher levels of public spending on social welfare – such as on unemployment programmes, housing support and income maintenance – has been found to improve health outcomes and narrow health inequalities.^{109,110,111,112,113} This is particularly important for those with low educational attainment levels and those with long-standing health problems.^{114,115} While it is often argued that investing in the welfare state undermines productivity, efficiency and economic growth, there is countervailing empirical and historical evidence showing that large welfare states do not appear to hamper economic growth.^{116,117} An important mechanism for improving health and wellbeing, reducing social and health inequalities, and thereby improving productivity and human capital (the economic value of an individual's skills, knowledge and experience), is therefore **through investment in social protection**. This investment underpins many of the actions set out in the Marmot Review highlighted in section 3.1.

“Mainstream macroeconomics is crystal clear on what the evidence shows, that austerity damages health...and cutting child welfare programmes, cutting support for the elderly, cutting unemployment benefits, cutting expenditure on social programmes of all forms is bad for health and bad for health inequalities.”

Professor Sir Michael Marmot, former BMA President, speaking at the 2016 BMA Special Representative Meeting.

Considering this evidence in the context of changes to welfare spending highlights concerns about the impact of austerity and associated reforms. While welfare spending in the UK has risen steadily in cash and real terms over the past 30 years, there has been no significant change in spend as a proportion of national income during this period (as the average income has been broadly in line with growth in the economy).¹¹⁸ Between 2014-15 and 2019-20, spending is expected to fall both as a share of GDP and in real per capita terms – total welfare spending in the UK is projected to fall by 1.3%, and spending subject to the welfare cap by 0.9%.¹¹⁴ This projected trend is at odds with the need to maintain high levels of investment in social support systems, and is likely to diminish the protective capacity of the welfare state. Action is therefore needed to reverse this **through increased investment in social protection systems across the board, and, in particular, for the most vulnerable populations**.

Beyond social protection mechanisms, **investment in health (including healthcare and public health services) is vital**. This has direct and indirect impacts on health outcomes, with investment in health known to have especially high fiscal multipliers (a measure of the effect of government spending on economic growth).¹¹⁹ This is particularly important in the context of decisions taken to reduce expenditure in the short term as a necessary condition to promote economic recovery. A 2013 analysis of comparative cross-national data on sector-specific funding among 25 EU countries from 1995 to 2010 found that government spending on health can have short-term benefits that may make economic recovery more likely, as well as contributing to economic growth in the long term.¹¹⁵ This highlights the

need for greater overall investment in healthcare in the short and long-term, which sits in stark contrast to the predicted decline in public spending on health (falling to 6.7% of GDP by 2020/21).⁵ It is important to ensure that an overall increase in funding for health does not come at the expense of reduced funding for services and other budgets that impact on health and wellbeing (such as education, housing and communities).

It is also important to protect those areas of funding that are often considered as easier to cut in response to financial pressures, such as ill health prevention and early intervention services. As has been seen in England, funding for public health services has been subjected to severe cuts (see **Figure 4**). While there is limited evidence in this area, a 2013 report from the European Public Health Alliance recommended that in a time of austerity, rather than cutting preventative services, a greater reallocation of health finances focused on disease prevention and health promotion is likely to be the most cost-effective approach and contribute to a more productive working population.¹²⁰ It is therefore important to **prioritise, protect and**

increase investment in evidence-based preventative medicine and early intervention services, which should not be provided through funding reallocated from other parts of the health budget. This approach requires a clear recognition that the benefits of investing in prevention can take many years to be realised. Cuts that impact on health prevention and intervention may be particularly short-sighted, only extending the impact of austerity, with the full effects likely to be translated as greater future reliance on health services.

“Improving the health of our nation is not just our responsibility. It’s not just the responsibility of healthcare providers like us. It’s not just about having enough doctors. It’s not just about having enough, good enough medication to treat disease when it arises. Respiratory disease is tackled by reducing air pollution, it’s tackled by reducing smoking, and dealing with inadequate housing. It’s about prevention.”

Dr Sally Winning, associate specialist, Aberdeen

Figure 4 – public health funding cuts in England

The 2015 Comprehensive Spending Review revealed a cut to public health budgets of 3.9% a year.¹²¹ This is in addition to the 2015/16 in-year cut of 6.2% to local authorities’ public health grant (equating to a reduction of £200 million),⁵ which has been described as ‘the falsest of false economies’.¹²² Public health funding is already stretched to the limit and these further cuts mean that local authorities will struggle to fulfil even their statutory responsibilities, let alone provide additional services that will improve population health. The swingeing cuts to the public health budget are at odds with the Government’s expressed commitment to protect and invest in public health services. Cuts to the public health grant will inevitably lead to service reduction and will, in the longer term, result in greater costs for both the NHS and the taxpayer. While it is too early to assess the impact of these cuts, there is evidence that local authorities are disinvesting in areas such as prevention, addiction services, sexual health, and weight management.^{123,124}

Does health need to suffer during and after a financial crisis?

Experiences in other countries demonstrates that, during and after periods of recession and financial crisis, investment in public health and social welfare programmes— housing support, unemployment programmes, old-age pensions, and healthcare – improves health and reduces health inequalities.

Extensive research by Stuckler and Basu looking at the impact of financial crises, and varying responses to them, found that ‘...societies that prevented epidemics during recessions almost always had strong safety nets, strong social protection.’¹²⁵ The premise of their view is that austerity policies typically undermine key social policies that help people return to work, maintain their incomes and support economic stability. The authors support the use of evidence-based public health and social protection policies, and highlight that governments that have responded to financial crises by increasing public-sector spending have seen faster economic recoveries and better health outcomes.

Their analysis of the impact of the recent period of recession portrays a similar message. They found that Iceland’s response of increasing health service budgets and maintaining its social protection mechanisms not only maintained public health standards but also began to see positive economic growth by 2011. Health in other countries that took similar approaches (such as Sweden, Canada and Norway) also improved. In contrast, the cuts to health care spending in Greece following the start of the recession led to a decline in public health standards (including malaria outbreaks and rising HIV rates).

3.3 Assessing the impact of all policies on health

As this briefing emphasises, economic and social policy strongly impacts on physical and mental health, with those policies that affect income and employment being particularly important. When coupled with the evidence of the detrimental impacts of austerity policies and welfare reform, there is a clear need to ensure that health and wellbeing are a primary consideration in policy decisions. **The BMA therefore strongly supports a ‘health in all policies’ approach.** This would ensure that the impact on individual and public health is accounted for in the nation’s economic strategy and decisions on social policy. In practice, this would require public bodies to undertake a form of pre-decision assessment through the use of an HIA (health impact assessment). Such an approach is also likely to better support integrated cross-government working in relation to improving health, which is an area where there has traditionally been poor leadership (as typified in England by the disbandment of the cabinet subcommittee on public health in 2012).

An HIA is a well-established tool for this role, focusing on how policies influence social determinants. The WHO (World Health Organization) defines it as ‘...a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques.’¹²⁶ This process helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health.¹²² A definition known as the Gothenburg Consensus describes HIA as a combination of procedures methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.¹²⁷ In light of the financial pressures discussed throughout this briefing, an assessment should consider cost-effectiveness, including the impact of investing in prevention as a way of achieving benefits in the long term.

“There needs to be a real look across government at the impact of policies on health. This will help overcome the silo working typical of government departments that can mean they develop policies without due consideration of the impact in other areas, such as health.”

Dr Mark Porter, BMA council chair

Despite the existence of various guidelines on how to conduct a HIA,^{128,129,130} as well as a framework developed by the European Commission,¹³¹ they are only used to a limited extent in the UK. There is a need for **a mandatory requirement for all government departments and public bodies to undertake an assessment of the impact of all new policies and policy changes on health.** This will ensure greater consideration of the negative impacts on physical and mental health in decision-making, and focus attention on ways in which these can be mitigated. It would help to avoid unforeseen health impacts

and maximise positive health benefits. In recognising the potential scale and demands of this recommendation, consideration should be given to how it is phased in and applied to selected policy areas initially, before being rolled out to be part of any policy for which an impact assessment would be conducted. In addition to prospective assessment, consideration is also needed as to how an HIA is used to monitor widespread systems (such as welfare payments), when they are undergoing radical change over several years.

Supporting HIA in Wales

Sustained lobbying by BMA Cymru Wales during the 2011-16 Welsh Assembly term secured cross-party support for a statutory requirement to be in the Welsh Government's Public Health (Wales) Bill for an HIA to be carried out under certain circumstances.

The Welsh Government first signalled its intent to introduce legislation aimed at delivering improved life expectancy, well-being and reducing health inequality in 2011.¹³² This led to a Green Paper in 2012, seeking views on using legislation to make an HIA mandatory, and what bodies, and in what circumstances, this should apply. Despite a high level of support, and a clear majority of respondents having indicated that the Welsh Government and Welsh local authorities should be subject to such a requirement, the concept was dropped from being considered in the Public Health Bill in 2014. At this stage, the Welsh Government stated that it would be incorporated in the Well-being of Future Generations Bill (now an Act). In responding to the development of the latter, BMA Cymru Wales expressed concern about the effectiveness of this approach in the proposed legislation because the requirement was implicit, vague and open to interpretation.

BMA Cymru Wales subsequently increased its lobbying for a mandatory requirement for a HIA to be included in the Public Health (Wales) Bill, including providing written¹³³ and oral¹³⁴ evidence to the Assembly committee charged with responsibility for scrutinising the Bill. They also secured a written submission making the same call which was co-signed by 21 other Welsh stakeholder organisations. As a result of these and other continued lobbying efforts (including an organised email campaign from grassroots BMA members) a recommendation from the committee was secured that a requirement for an HIA in defined circumstances should be incorporated into the Bill. An opposition amendment to include such a requirement then followed at the next stage in the Bill's consideration, and this triggered a Government amendment at the third stage.

Despite this Government amendment then being agreed with full-cross party support, the measure did not subsequently make it into law. An argument over other aspects of the Bill led to it unexpectedly failing to pass on the final Plenary session before the Welsh Assembly was dissolved ahead of the 2016 elections.

BMA Cymru Wales is committed to continuing to lobby for the proposal to be enacted in law and it is hoped that the legislation will be re-introduced during the new Welsh Assembly term.

4 Doctors as advocates

Doctors have a long history tackling major public health concerns and are in a unique position to advocate for the health needs of their patients and the wider population. They have a vital role in highlighting how social and economic factors impact on health and wellbeing. This is particularly important in providing a voice for the most vulnerable and disadvantaged in society who suffer disproportionately during periods of austerity.

Key to this advocacy role is arguing for the impact on health to be considered in policy development, and for action to tackle the social determinants of health. While these areas typically lie outside doctors' clinical reach, their knowledge and understanding of health, as well as their trusted^h position in society, means that they can have a strong influence on policy decisions. This can be through action in their workplace and local area, or by influencing national and international policy.

The following provides some suggested ways in which doctors can act as advocates. It is not meant to be an exhaustive list, or be prescriptive about what should be done, but provides examples of the type of activities doctors can undertake. Equally, the intention is not to replace or counter ongoing relevant projects or work programmes. So for many, finding out what is already happening and getting involved in existing initiatives is likely to be the best approach.

Action in the healthcare setting

Practising doctors are able to work directly with patients, other health professionals, commissioners and healthcare managers in advocating for action. Whether this is as a GP running a practice, a hospital-based doctor, or a public health doctor responsible for health promotion and disease prevention in the local area, there are opportunities to help shape the response of the healthcare setting.

Practical ideas for action

1. Consider how to improve patients' health literacy so they better understand the factors that can impact on their health and wellbeing.
2. Provide links to non-medical sources of support within the community (ie 'social prescribing') (see **Figure 5**).
3. Develop local strategies to empower patients from vulnerable and socially excluded groups in accessing primary and community health services (such as patients with poor mobility, learning difficulties, autism and other disabilities, and patients with chaotic lives).
4. Encourage all healthcare organisations to assess the impact of policy changes on health and wellbeing.
5. For those with commissioning responsibilities:
 - develop patient-focused, integrated services across health, public health and social care that have links with other public services at a regional/local level;
 - prioritise the commissioning of services that promote and maintain health, to complement services for the treatment of disease and injury.
6. If not actively involved in commissioning, encourage local planners or commissioners to take a more holistic approach to commissioning and public service policy development.
7. As a GP, get involved with your local medical committee to shape the way it represents GPs in the local area on this matter.

^h A poll by Ipsos MORI ('Trust in Professions') published in January 2016 found that doctors are the most trusted profession, with 89% of the public trusting them to tell the truth (Source: www.ipsos-mori.com/Assets/Docs/Polls/ipsos-mori-veracity-index-2015-charts.pdf last accessed 19 April 2016).

Figure 5 – social prescribing

Social prescribing can be defined as ‘...a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, new skills, volunteering, mutual aid, befriending and self-help, as well as support with benefits, employment, housing, debt, legal advice or parenting problems.’¹³² It is usually delivered through primary care and, although a range of referral models and options exist, appropriate community structures (eg third sector agencies) need to be in place to support referral. A review which evaluated 35 social prescribing schemes in the UK found that they can help patients by increasing their self-esteem, confidence, sense of control and empowerment; improving their psychological or mental wellbeing; and reducing symptoms of anxiety and depression.¹³³ It is worth noting, however, that there is limited good quality evidence of the effectiveness of commissioning specific social prescribing programmes, with the best evidence for the positive effect of referral schemes in primary care on physical activity and improving health outcomes.¹³⁴

Action in the local community

With an increasing focus on decision-making and policy development at a local level, doctors can use their influence and professional insight to shape community activities and priorities.

Practical ideas for action

1. Find out how to influence local policy decisions (eg around housing management, provision of children’s services and disability services, and educational policies), and consider how these will impact on the health and wellbeing of the people in the community.
2. Lobby local authorities to undertake an HIA on their policy and planning decisions.
3. Consider how you can directly influence decisions (eg standing for election as a local councillor, getting involved in a local strategic partnership or acting as a school governor).
4. Get involved in local community projects and networks.

Influencing national and international policy

Doctors can be powerful and effective lobbyists in informing and influencing policy. With decisions made every day in the UK and the EU on policy, legislation and regulation, governments depend on a constant flow of information and views from those who may be affected by their actions. Doctors can influence these decisions by forming a strong, collective voice, and by understanding the pressure points in the system where they can effectively make a difference to policy development.

Practical ideas for action

1. Consider what health-based arguments should be made to policy makers to represent the best interests of patients and the health of the public.
2. Encourage and get involved in action by professional associations and bodies, including the BMA and medical royal colleges.
3. Get involved in a health-based network or share experiences with health organisations (eg providing information on projects or programmes aimed at reducing health inequalities with the [Institute of Health Equity](#)).
4. Influence the political process directly by writing to local councillors and/or relevant elected representatives to highlight key concerns about the impact of policy proposals on health and wellbeing.

5. Concluding remarks

This briefing sets out doctors' concerns about the negative impact of austerity and associated welfare reform on health and wellbeing, which is disproportionately affecting the most vulnerable. With further budget cuts due to be implemented, the potential for individuals to be negatively affected will increase, and there is a risk that health inequalities will widen.

Action must therefore be taken to mitigate these effects. This should focus on alleviating existing inequalities that have been worsened by austerity and welfare reform, and preventing future policies from having further adverse effects. Both will require consideration of the role of the social determinants of health and the impact of future policy changes on health and wellbeing.

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