Health, wealth and wellbeing

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The SOLACE Foundation Imprint (SFI) is local government’s foremost thought leadership publication addressing the most pressing and challenging issues of public policy and public management. SFI commissions concise contributions on the major themes which are central to the concerns of senior executives, policy makers and politicians. We are resolutely non-political, though we recognise and actively address the importance of political leadership and debate in developing public services. We publish a range of voices that pose challenges to senior public executives and show how challenges might be met. We believe our strength is in the range and diversity of ideas we publish because the world is more complicated than any contrived consensus. Through SFI many flowers are encouraged to bloom.

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## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Foreword: Resilience to cope in hard times</td>
<td>Michael Bichard and Rob Whiteman</td>
</tr>
<tr>
<td>6</td>
<td>Weathering the storm</td>
<td>Martin McKee</td>
</tr>
<tr>
<td>9</td>
<td>Ash clouds and adversity</td>
<td>Tony Coggins and Sherry Clark</td>
</tr>
<tr>
<td>12</td>
<td>Councils, health and prosperity</td>
<td>David Rogers</td>
</tr>
<tr>
<td>15</td>
<td>Adding life to years</td>
<td>Geoff Alltimes</td>
</tr>
<tr>
<td>18</td>
<td>Inequality: the enemy between us</td>
<td>Richard Wilkinson and Kate Pickett</td>
</tr>
<tr>
<td>20</td>
<td>Financial security and poverty</td>
<td>John R Ashton</td>
</tr>
<tr>
<td>23</td>
<td>Prevention services, what next?</td>
<td>Eddie Clarke</td>
</tr>
<tr>
<td>26</td>
<td>Ethnicity, poverty and health</td>
<td>Sarah Salway</td>
</tr>
<tr>
<td>30</td>
<td>A partnership approach</td>
<td>Richard Leese</td>
</tr>
<tr>
<td>32</td>
<td>Public health: society’s business</td>
<td>Angela Mawle</td>
</tr>
<tr>
<td>36</td>
<td>CAB: a local solution to local problems</td>
<td>Elizabeth Ladimeji</td>
</tr>
<tr>
<td>40</td>
<td>Leading through the economic crisis</td>
<td>Derrick Anderson</td>
</tr>
<tr>
<td>43</td>
<td>Local health and resources</td>
<td>Mai Stafford and Mel Bartley</td>
</tr>
<tr>
<td>46</td>
<td>Local support for tight budgets</td>
<td>Alison Seabrooke</td>
</tr>
<tr>
<td>52</td>
<td>Teaching resilience in schools</td>
<td>Nicola Bacon</td>
</tr>
<tr>
<td>55</td>
<td>Global downturn and health</td>
<td>Rosalie Callway and Rachel Palma</td>
</tr>
</tbody>
</table>

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The UK economy is recovering from what many commentators refer to as one of the worst recessions in recent history. The impact of the recession on the public sector is likely to be felt for many years to come. How local government, and the public sector more widely, achieves the difficult balancing act of making tough spending choices and improving the health and wellbeing of local communities will be a recurring theme. The scale of the challenge is enormous, but there are opportunities too. Local government has much to offer: leadership; innovation and efficiency; partnership working across the public sector; and wrap-around services that strengthen individual and community resilience to cope in hard times and enjoy good health and wellbeing at all times.

This collection of essays aims to contribute to the debate about some of the major challenges and opportunities facing local government and the public sector in improving health and wellbeing in times of reducing public sector finance. Produced jointly by SOLACE and the IDeA, the pamphlet draws together a range of different perspectives – elected members, leading policy-makers, practitioners and academics – to promote better understanding about the impact of economic change on public health.

The articles in the first half of the pamphlet argue for, and demonstrate the importance of, local government’s role in public health. Several overarching themes are examined:

- How to transform public services.
- Leadership and partnership working.
- The case for investment in prevention.

The articles in the latter half focus on some practical projects and initiatives to mitigate the negative health effects of the recession on health and wellbeing, ranging from debt recovery advice, community self-help initiatives to wellbeing projects with young people. A key message is that people are much more likely to stay healthy and cope in adverse times when they have access to social networks. We are also reminded that, irrespective of whether or not they are disadvantaged, all communities have assets of citizens and resources that should be supported, nurtured and
encouraged by local government and health partners.

We also hear about what happens to people's health in difficult economic times, and the specific issues for ethnicity and health inequalities.

Highlighting experiences from past recessions and European research, contributors show that financial crisis can have different effects on health. Although economic recession can result in increased risks in suicides, stress and mental disorders, alcohol consumption, drug use and poor diet, it can also lead to a reduction in traffic accidents and fewer fatalities as more people switch to public transport and walking instead of driving – leading to lifestyle changes and benefits to the environment.

On the other hand, people are more likely to buy snacks and eat at cheaper fast food restaurants, consequently storing up health problems for the future.

With the formation of a new coalition government in the UK for the first time in nearly 70 years, the future direction for public health will no doubt change. This pamphlet provides a wealth of evidence, information and views that could contribute to informing a future public health agenda in which local government plays a leading role.

We would like to give our personal thanks to everyone who has contributed to this important topic.

Lord Michael Bichard is Editor in Chief of the SFI

Rob Whiteman is Managing Director of the Improvement & Development Agency (IDeA) which works with leading edge councils, accelerate the pace of improvement for all authorities and ensures the development of local government to meet its challenges
The 2008 global economic crisis has not spared the United Kingdom. It is in a better position than many of its neighbours, with a lower ratio of debt to GDP, the good fortune to have structured its debt so that it has much longer before its needs to refinance this debt (IMF, 2010), and emerging evidence of recovery, with the 2009-10 deficit £11bn less than predicted. Nevertheless, the government has begun to reduce its spending to compensate for the temporary fall in tax revenues and the cost of bailing out the banks during the crisis. This will have consequences for health.

**Economic dislocation**

Thanks to a growing body of research, we now know much more about how people respond to the adversity that accompanies economic dislocation. The loss of a job is a major life event, comparable to a bereavement. The consequences are both long term, as people adopt health-threatening behaviours, such as smoking and hazardous drinking, and short term, with increases in suicides. Worse, many of these effects are seen not only in those losing their jobs but those in fear of doing so. Yet we also know that individuals and communities can show remarkable resilience, a phenomenon portrayed clearly in the 1996 film Brassed Off, in which a mining community facing closure comes together around the colliery’s brass band. This is social capital in action. Those that prefer more quantitative evidence may instead look to the experience of European countries emerging from communism in the 1990s. Those where over 30% of the populations were members of organisations, such as churches, trade unions, or social clubs, were spared most of the increase in mortality that accompanied major economic restructuring (Stuckler et al., 2009a). Governments can also play a role, as seen in the experience of western European countries in the past three decades. Those spending even quite small amounts on active employment schemes when faced with recessions were able to avoid the rise in suicides seen in those that did not (Stuckler et al., 2009b).

The contributions to this SFI
pamphlet provide many examples of how individuals, communities and, especially, local government, can provide support in the face of economic uncertainty and adversity. Tony Coggins and Sherry Clark recall how people stranded by the Icelandic volcano reacted in very different ways and ask what can be done to promote the mental wellbeing required to cope with an uncertain future. David Rogers sets out the case for action by local government, putting setting out the economic arguments for doing so and drawing attention to existing initiatives, such as Total Place, to streamline services and thus deliver services more efficiently. John Ashton provides an historical perspective, showing how local government had driven health improvements in the past and, in many places, is doing so again. Geoff Alltimes continues this theme, describing the benefits of joint working between local government and the NHS. Derrick Anderson stresses the importance of leadership and vision, especially in times of recession. Richard Leese focuses on younger people and stresses the importance of fostering aspiration while providing opportunities, in his case taking advantage of Manchester’s two world class football clubs to deliver health training to unemployed young men. Eddie Clarke, rather provocatively, asks whether, when money is short, it is better to focus on immediate needs at the expense of prevention, but concludes that, even on economic grounds, it is not.

Richard Wilkinson and Kate Pickett step back to look at the distribution of resources within society. Drawing on their book, *The Spirit Level*, they point out how less equal societies are bad for everyone, regardless of whether they are at the top or bottom of the hierarchy (a finding, as they note, that applies to monkeys as well as humans). Mai Stafford and Mel Bartley show how people’s environments influence their wellbeing, beyond their individual attributes. Sarah Salway draws our attention to the disadvantage faced by many minority ethnic communities, a result in part due to their worse economic situation but, in many cases, also due to racial exclusion. Angela Mawle highlights the importance, in promoting public health, of the “organised efforts of society”, which she illustrates with examples of innovative working from across the country. Elizabeth Ladimeji takes us to a much more local level, flagging up the valuable contributions made by the volunteers who staff the Citizens Advice Bureaux. Alison Seabrooke draws our attention to the work of the Community Development Foundation and its support for small organisations finding local solutions. In a similar vein, Nicola Bacon from the Young Foundation describes how schools can help their pupils develop the resilience they will need when they transition to the world of adulthood.

Finally, we have a reminder that the UK is not unique, as Rosalie Callway and Rachel Palma look to the consequences of the global economic downturn. In 2008, just before the recent financial crisis, European governments met in Tallinn, Estonia. The theme of their meeting was health systems, health and wealth (*McKee et al., 2009*).
The array of evidence presented to them set out two options. Europe could disinvest in health and health systems, entering a vicious downward spiral of economic decline, poverty and disease. Or it could invest in health systems, and the other pre-requisites for economic growth, so entering a virtuous cycle of health, wealth, and wellbeing. What was true at a time of prosperity is equally true at a time of economic retrenchment. This pamphlet shows us how, even in the face of serious financial threats, non-governmental organisations and councils across the UK are working to strengthen the resilience that is needed to weather the storm.

References

Martin McKee CBE is Professor of European Public Health at the London School of Hygiene and Tropical Medicine and Director of Research Policy at the European Observatory of Health Systems and Policies, a partnership of governments, international agencies, and universities
Wellbeing: "A dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society" (Mental Capital and Wellbeing, Foresight, 2008.)

**Coping with adversity**

When the ash cloud from the Icelandic volcano effectively closed Europe for business, it provided some great illustrations of how people deal with adversity. Some intrepid souls faced the challenge head-on – demonstrating astounding creativity and ingenuity in outwitting Mother Nature. Others sat back, ordered another margarita and waited for the dust to settle. Still others collapsed in disbelief and gave up any hope of a solution – demonstrating a classic response to stress that American psychologist Martin Seligman has identified as “learned helplessness”.

The ways in which individuals react to adversity is a fascinating study. There is a growing body of evidence that demonstrates very clearly that there are particular characteristics and attributes that enable some people to thrive in troubled times, while others struggle to survive. This has great significance for public policy at this time of economic downturn as people are exposed to increasing rates of unemployment and redundancy, personal debt and house repossessions. According to some commentators, we could face as much as a 25% rise in some mental health problems, particularly depression and anxiety-related disorders, as a direct consequence of the current recession. The UK is having to face up to the combined reality of an unpredictable world and unsustainable economic practices. People are being hard hit at a very personal level: a level that has long-term emotional, psychological and physical health implications.

**Five ways to wellbeing**

With this very challenge in mind, the Foresight project (see www.foresight.gov.uk) looked at the psychological resources people will need in the future. The project found evidence that people with higher levels of mental capital and
wellbeing live longer, are healthier, learn quicker, are more productive, do better in relationships and are more pro-social. The New Economics Foundation condensed the findings into a series of pithy headline messages which tell us the things we all need to do more of to ensure future stocks of ‘mental capital and wellbeing’:

**Connect**: people are social and need contact with others. People with five to eight close connections live on average seven years longer than those without.

**Be active**: physical activity improves both physical and mental health.

**Take notice**: learning to appreciate our surrounding helps to offset the stress of comparing “our lot” unfavourably to others.

**Keep learning**: habits of lifelong learning are strong protectors against degenerative brain diseases like Alzheimer’s and dementia.

**Give**: giving time and help to others not only creates community connections and fosters a more altruistic society – it lowers blood pressure as well.

### Impact of inequality on resilience and wellbeing

While the Foresight project has done a great deal to improve our understanding of what individual actions will ensure mental capital for the future, the messages are individual calls-to-action that need to be understood in the context of economic and social inequality in the UK.

Both the Marmot review (Fair Society, Healthy Lives, UCL, 2010) and Richard Wilkinson and Kate Pickett’s work (The Spirit Level, see p. 18-20) very clearly demonstrate that strategies for improving both individual and community wellbeing can only succeed if they take into consideration the degree to which social and economic inequality limit both life chances and life-expectancy. In effect, appreciating that inequality will dilute efforts to build resilience and foster wellbeing as long as such stark imbalances exist. Put simply, in order to increase mental capital we will also need to reduce inequality; this is not an either/or situation.

### Applying the research in communities

Since 2007, the multi-agency Well London programme has been considering the ways in which London’s inequalities in health and wellbeing might be faced head-on, by incorporating the principles of community development into a wide-ranging public health improvement initiative. Over five years, Well London aims to improve health and wellbeing in 20 communities experiencing the worst effects of the city’s inequalities.

As Well London’s lead partner for mental wellbeing, the South London and Maudsley NHS Foundation Trust (SLaM) has been piloting a series of projects designed to promote wellbeing and improve public awareness of the actions needed to reduce the impact of inequality and enhance positive mental health.

Through delivery of these
programmes, we have learned that in order to build mental wellbeing “the way you do things” is as important as “what you do”. Because wellbeing is a combination of how people think, feel and function, how programmes, services and organisations make people feel have a significant impact on their mental wellbeing and consequently what people then do.

One of the tools that we used to ensure that the programmes maximised their positive impact on mental wellbeing and minimised the negative was the Mental Wellbeing Impact Assessment (www.hiagateway.org.uk). The toolkit is based around four factors identified by the Department of Health that are strongly associated with positive impacts on mental wellbeing:

- Enhancing control.
- Increasing resilience and community assets.
- Facilitating participation.
- Promoting inclusion.

**Wellbeing is everybody’s business**

What is striking about the factors that promote and protect mental wellbeing is that they are largely outside the realm of mental health services. They are built and reinforced in schools, workplaces, families and communities. Therefore how we fare in this recession will depend far more on how others protect and ensure mental wellbeing through increasing people’s sense of control, building resilience, supporting valued roles (participation) and creating a sense of belonging (inclusion), than how effectively mental health services are able to deal with the fall-out of increased mental illness from the recession.

*Tony Coggins is head of mental health promotion at the South London and Maudsley NHS Trust (SLaM). SLaM is the lead partner for mental wellbeing in Well London, a five-year Lottery-funded programme seeking to improve wellbeing in 20 communities across London facing the greatest inequalities*

*Sherry Clark is a member of the mental health promotion team at South London and Maudsley NHS Foundation Trust and co-ordinates the Well London Do-It-Yourself Happiness project*
The roots of public health
The notion that health gain and addressing health inequalities is a core purpose of local government is not new. Indeed, the foundations of municipal government lie in the pressing need to address the great public health problems of the 19th century. It was local government that overcame the squalor and disease of industrialisation by leading a public health revolution. Councils pioneered the provision of clean water, slum clearance, universal education, food inspection, the creation of parks and gardens and public health promotion.

Since then, councils have seen their ability to play a significant role in health improvement diminish. The creation of the National Health Service, though a magnificent achievement in bringing free health care to millions, led to the growing misconception "that anything to do with health and ill-health is surely the business of the health sector and, primarily, the NHS" (Marmot, 2010).

This is now changing. There has always been a small band of public policymakers that has continued to argue that health improvement should be at the heart of local government, and this view has steadily gained ground. Since 1998, there have been mandatory national and local targets to reduce health inequalities, with additional funding for the poorest areas. This was followed by the Local Government Act 2000, with the duty to promote the economic, social and environmental wellbeing of the area. Health is clearly a fundamental component of this.

Progress so far
But where has this centrally-driven approach to improving people’s health, particularly the worst off in society, got us? The disheartening answer is not very far at all. The Marmot review found that while life-expectancy has increased for everyone since 1998, the gap between the richest and the poorest is roughly the same. On average, people living in the poorest neighbourhoods will die seven years earlier than those living in the richest areas. People living in poorer areas also spend more of their lives with a long-term condition or disability – an average difference of 17 years. The stark lesson from the Marmot review and the government’s own assessment of the
drive to address health inequalities is, though health has improved for everyone, including disadvantaged groups, “the gap is no narrower than when the targets were first set” (Department of Health, 2009).

**Achieving health and prosperity in a hostile climate**

So what is the answer to the seemingly insoluble challenge of improving the health of all our citizens? Moreover, how can we afford to do this in such a harsh economic climate? The short answer to the question of affordability is that we can’t afford not to act on health improvement:

- The Marmot review estimated that the inequality of illness costs the economy between £56bn and £60.5bn a year in lost productivity, lost taxes, increased welfare and benefits payments, and health costs of treating ill-health.
- The economic benefits of moving the pensionable age to 68 will largely be counterbalanced by the prediction that at least 75% of 68 year olds will have long-term conditions that limit their ability to remain economically active.

Health improvement is essential if we are to achieve prosperity for all our communities. Health and prosperity go hand-in-hand and it is impossible to achieve economic health without achieving significant health gains – especially among those with the poorest health and poorest economic prospects.

We need to change fundamentally the way the public sector works to ensure that we make the most of scarce resources, and to achieve better health. It is early days, but the answer may lie in Total Place. The Total Place approach, simply put, is about how the local public sector as a whole can work with others to plan and provide better services and achieve better outcomes for less. Moreover, it is about redesigning services and budgets to better meet the needs of customers.

The 13 Total Place pilot areas focused on different themes – children's services, drug and alcohol abuse, employment, older people, offenders, to mention just a few – but almost all had a strong health and wellbeing element. The final reports of individual pilots have now been published (see www.localleadership.gov.uk/totalplace/totalplaces) and many of them identified the need to direct resources ‘upstream’, towards prevention and early intervention, minimising or avoiding recourse to more costly later interventions.

**Local freedom to lead**

The LGA is campaigning for a wholesale redesign of public services, with a strong emphasis on investing in preventative measures to achieve the aim of doing ‘better for less’ (LGA, 2010). We also identify barriers to a Total Place approach and some solutions for overcoming them:

- From centralism to localism – local government, the NHS and other key organisations all have a heavy burden of targets imposed by national government, which makes it difficult for them to focus their efforts on a small number of local priorities. Local organisations need the freedom to set
their own local targets, led by local councils in dialogue with their communities.

- Financial freedoms – although there have been some efforts to align health and social care funding to make joint working easier, there are limited incentives for councils to invest in ‘upstream’ infrastructure improvement directed at better health outcomes because the savings accrue to the health service years into the future. The report Valuing Health underlines this flaw in the system (IDeA, 2010).
- Focusing on the future – there is a growing body of evidence that short-term programmes such as the Partnerships for Older People Projects (POPPs) and LinkAge Plus focusing on prevention and early intervention can achieve better health and wellbeing outcomes and save money. But the entrenched problems of persistent poor health outcomes, coupled with economic exclusion, cannot be achieved by short-term measures alone. Local councils and their partners need the freedom to put in place long-term plans to improve social and economic infrastructure. All too often, national initiatives and requirements make it difficult for local councils to stay focused on the bigger picture.

I am not underplaying the scale of the challenge facing national and local government over the next decade.

Turning the tide of our increasing health challenges would be difficult enough in a time of economic growth. But in the words of Rahm Emanuel, chief of staff to President Obama: “Let’s not waste a good crisis!” Local councils, local agencies and communities have the vision and insight to address the wicked issues of poor health and poor economic performance: they need to be given the freedom and support of national government to find local solutions to the global crisis.

References
Department of Health (2009), Tackling Health Inequalities: 10 Years On (London).
IDeA (2010), Valuing Health (London).

Cllr David Rogers OBE has been involved in Sussex local politics for over 30 years. He is currently vice chair of East Sussex’s Health Overview and Scrutiny Committee, and is chair of the Local Government Association’s Community Wellbeing Board
Like much of England, Hammersmith & Fulham has been improving in many health inequality measures over the past 20 years. However, this has masked a widening gap between those who have done well in the good economic times and those who haven’t. It is obvious that a determinant of which of these groups we fall into, depends primarily on the state of our health: what Sir Michael Marmot would describe as the “social gradient in health”. In the current economic climate, there is a threat that this will become even more pronounced as those who are healthy, well educated and more affluent are better equipped to adapt to the new economic reality.

However, Richard Wilkinson and Kate Pickett made the case in The Spirit Level, that economic growth and improved material conditions in developed countries have delivered all the health benefits they are likely to (see p. 18). Indeed, the more unequal developed societies, such as the UK, tend to do worse in terms of health outcomes. So does the current economic situation offer opportunities to address some of our health inequalities and improve the wellbeing of our communities?

Better lifestyle choices
In line with Marmot’s findings, I believe that tackling health inequalities requires action by all central and local government departments. However, as the pressure on public finances grows, the political imperative is for efficiencies to be made, rather than cutting services. It is no longer acceptable, or affordable, to retain artificial barriers between public services or expect our residents to navigate the plethora of agencies that provide the services they need to make a difference to their lives.

Traditionally, deprived groups have consumed the lion’s share of public expenditure receiving the poorest services and getting the poorest outcomes. The only way to reduce public expenditure without cutting services is to reduce the demand for expensive acute interventions by reducing the need for them in these socio-economic groups. This can only be achieved by prioritising preventative interventions early, so that expenditure on health and social care stops growing, public health improves and everybody wins.

The challenge we face is how to transform those services to promote the
wellbeing of our communities, so that they are able to adapt and make the most of the opportunities and choices available. We need to support them to raise and realise their aspirations so that reduced life-expectancy and years of avoidable poor health don’t result in their only lifestyle option being incapacity benefit.

All breakages have to be paid for
For too long, the role of both local government and the National Health Service has been to pick up the pieces after things have gone wrong. When someone becomes homeless the council will house them, when someone becomes ill the NHS will treat them. All too often what we do is too little, too late and costs too much.

The NHS and local government complement each other as the two big universal public services (arguably the police and work and pensions could be included). The access that councils have to the most vulnerable and deprived communities means that they are ideally placed to undertake early interventions, in housing, early years, leisure and recreation, not to mention social care. Therefore, councils need to see their roles develop as actively promoting the wellbeing of their population, rather than as a passive commissioner of services. The NHS, in turn, needs to value and prioritise the role of preventive public health as much as it does clinical services.

Joining up the dots
Last year, in Hammersmith & Fulham, the council and the primary care trust (PCT) appointed a joint chief executive and established joint executive management arrangements. This provided the opportunity to remove many of the artificial barriers that were preventing us from providing services that would deliver the best outcomes for our service users. It is now becoming increasingly likely that a similar model will be adopted in a number of boroughs across London.

At Hammersmith & Fulham we, the council and PCT, are developing a model of integration around the development of a polysystem, which will go some way towards realising the six policy objectives identified in the Marmot review. The aim is to deliver not just improvements to primary health care, but support more effective social care and importantly deliver an improvement in preventative services not just for deprived communities, but universally across the population. The preventative approach isn’t seen as just encouraging people to stop smoking or drink and eat sensibly, because we need to address more fundamental issues by improving the socio-economic opportunities available to our communities by:

- Delivering better early child development and educational outcomes.
- Improved employment prospects.
- Better and joined-up public services.

These will equip people with the skills and knowledge to make their own lifestyle choices and determine the
quality of life which matches their aspirations, rather than living a life determined by a poor and limiting offer from fragmented public services, which at best does little to address the underlying problems which hold them back from realising their potential.

**Spotting opportunities in the face of austerity**

Ironically, the economic downturn may well be an opportunity, the prospect of shrinking public finances is driving public services to think about more integrated approaches to delivering services more efficiently with improved outcomes for communities.

In Hammersmith & Fulham, the PCT has recently established two polyclinics with the aim of improving primary care services. The next stage in this process will be to bring together social care, public health and other local authority services to establish a polysystem model to ensure that public services support the mantra of not just adding years to life, but life to years.

The implications for future local strategies are significant as it brings the concept of Total Place closer to reality. This will require a step change in community and business planning, as well as the pooling and management of financial and other resources to more effectively address local priorities as identified by local people.

I am optimistic for the future and see austerity as the mother of innovation. We have an opportunity to make a fundamental change in the way in which public services are commissioned and have a real impact in tackling health inequalities and improving the wellbeing of our communities.

**Geoff Alltines became joint Chief Executive of the London Borough of Hammersmith & Fulham and NHS Hammersmith and Fulham in 2009, leading a single integrated Executive Management Team serving the council and NHSHF. He has been the council's chief executive since 2002 and was previously the director of social services. He is currently the secretary of the Chief Executives London Committee (CELC) and a member of the London Health Integration Board**
Why do the poor suffer more than the rich from almost every health and social problem? Heart disease, infections and many cancers are much more common among the least well-off; so too are violence, drug abuse, obesity, teenage births and school failure. Do the most vulnerable and least healthy just end up at the bottom of the ladder? Or do lower material standards – poor housing etc. – cause these problems? Or is it something to do with intelligence or genetics?

**Status among monkeys**
Our research suggests that it is none of these. With humans it’s difficult to separate material standards of living from status itself. But keep Macaque monkeys in the same conditions and give them the same diets; then alter their status by moving them between groups. The result? The ones which move down develop many of the same disease risk factors, such as a build-up of cholesterol, that are associated with low status among humans. More junior civil servants working in government offices in London have higher levels of a blood-clotting factor called “fibrinogen”. Though junior civil servants rarely get bitten by their superiors, if you are a subordinate monkey facing the constant threat of attacks from dominants, you’d want your blood to clot faster.

**Income gaps and dysfunctional societies**
Now add to this picture the recent evidence that almost all the health and social problems related to social status – like heart disease, violence, teenage births – are all much more common in more unequal societies. Countries with bigger income gaps between rich and poor, like the USA, Portugal or the UK, are plagued by anything from two to six times as many of each of these problems as more equal countries like Japan, Norway, Sweden and Finland. Bigger income gaps make social status more important and all the problems related to social status get worse.

The relationships between inequality and each society’s burden of health and social problems have been checked not only among the rich developed market democracies, but also among the 50 states of the USA. In both settings there is a strong tendency for more unequal...
societies to do worse. Some of these relationships are now very well established: hundreds of studies show that more equal countries are healthier and at least 40 show they have lower homicide rates.

Greater inequality seems to make societies socially dysfunctional - right across the board. They do worse on physical and mental health, worse on violence, drugs, teen births, on how kids get on at school, obesity, the size of prison populations, levels of trust and social cohesion. Inequality seems to make almost everything go wrong.

People have always imagined that inequality is divisive and socially corrosive. The data shows this intuition is truer than anyone realised. What was a private hunch has become an objective and publicly demonstrable truth.

**Quality of life for everyone**

It is not just the poor who benefit from greater equality. Although they seem to benefit most, almost everyone - whatever their income - would do better if they lived in a more equal society. Middle-class people on good incomes do better in more equal societies: they are likely to live longer, be less troubled by violence and more involved in community life. Similarly, their children are less likely to fail at school, less likely to be bullied, less likely to succumb to drugs or to become teenage parents. In a really important sense, greater equality seems to improve the real quality of life for everyone.

More unequal societies are more stressful: inequality increases status competition and status insecurity. The data on trust, social cohesion and violence all show that greater inequality leads to a deterioration in the quality of social relations in society at large. We become less sociable and more out for ourselves.

Inequality also increases consumerism. Money, as an indicator of social status, becomes still more important; so people in more unequal societies work longer hours. As advertisers know, the fear is always that if we buy second-rate goods we will look like second-rate people. Violence is more common in more unequal countries because the most common triggers to violence are loss of face, people feeling looked down on and disrespected. In societies where bigger income differences make status more important, we become even more sensitive to how we are seen.

Rich societies have got to the end of the real benefits of economic growth. It no longer increases happiness or measures of wellbeing, and it no longer drives the increases in life expectancy. Having reached the end of what growth can do for us and facing the need to rein in carbon emissions, it is time to turn our attention from material standards to our social needs and the quality of the social environment.

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As we emerge from the general election, and the full implications of the global economic situation on the public finances finally begin to reveal themselves, the impact of cuts on people’s quality of life will come into sharp focus. The immediate concern is likely to be, election manifesto promises notwithstanding, that health and social care budgets will sooner or later come under the cosh to the detriment of public health and wellbeing. How big an effect will the cuts have and what role might local government have in ameliorating the impact of shrinkage in state-provided programmes and services?

Investment and health – not always linked
First and foremost, it may come as a surprise to many that the direct link between government investment in health and social care services and the health of the population can not be taken as a given. It has recently become apparent that the large increases in public investment in the NHS in recent years have not been met by commensurate improvements in health outcomes. Furthermore, in a well-publicised doctors’ strike in Israel some years ago there was a dramatic reduction in the number of recorded deaths (Siegel-Itzkovich, 2000).

It has been almost 40 years since Thomas McKeown published his influential book, The Role of Medicine: Dream, Mirage or Nemesis, and in this time the contribution of medicine to the public’s health relative to action in other policy areas has been hotly contested. McKeown argued, on the basis of a close examination of the trends in deaths from epidemics of common infections (such as tuberculosis) between the 1840s and 1970, that the key measures leading to dramatic declines in death rates had been environmental (largely led by local authorities), the greater availability of cheap food to the urban masses and smaller family size resulting from the adoption of birth control (McKeown, 1976).

This insight has underpinned much of the renaissance in public health since the 1970s, despite the wanton destruction in 1974 of the national public health system that had been based in town halls to great effect for...
over 100 years, and widely copied around the world (Ashton and Seymour, 1988).

As we face the challenge of the next 10 years, where the Victorian issue of providing drains and sanitation has been replaced by that of mobilising communities to care for large numbers of the frail elderly, often suffering from dementia, we must face the reality that we have never adequately replaced that previous system, that we have a set of fragmented public health arrangements without secure funding and a demoralised workforce that has been reorganised almost into submission by an NHS which neither fully understands, nor values, the importance of public health.

The health imbalance continues to top the scales
It is not as though there is no evidence base for what needs to happen. The Black report on Inequalities in Health, published in the dying months of the Callaghan Labour administration, provides the contemporary baseline. Sadly, it has never been used as effectively as was the case in 1842 with its predecessor, the Chadwick report, which galvanised the nation into public health action, led by the Health of Towns Association, and culminated within the space of a mere six years in the first Public Health Act (Ashton and Seymour, 1988). More recently, before bankers lost their credibility with the public, Sir Derek Wanless (2002) elegantly described the “fully engaged scenario” in which the support role of medicine was made clear in relation to the need for active health citizenship, based on a co-production model of health protection, improvement and management, only glimpses of which have since been seen. In a poetic rerun of the late 1970s, Sir Michael Marmot has now published his report, which powerfully assembles all the evidence on what we need to do together to rid ourselves of the shame of the massive inequalities in health and wellbeing which continue to blight our country (Marmot, 2010).

In these - whether it be giving every child the best start in life and enabling our young people to maximise their capabilities and have control over their lives; creating fair employment, a good standard of living and good work for all; creating healthy and sustainable places; or strengthening the prevention of ill-health - local government remains now as it was in 1848: the most likely institutional form to mobilise and shape those organised community efforts, which are so crucial to being able to respond to what is coming down the track at this time of austerity.

Time to invest with communities not cash
Two recently published reports by the IDeA help provide a route-map for the journey which is about to start (Campbell, 2010; Foot, 2010). Taken together, these two documents not only remind us of the resource which local government represents at its best and its scope for action, they also focus on the assets of citizens and the resources which are to be found in all communities, however stressed and disadvantaged. Drawing on over 40 years of work by John McKnight in
Chicago, whose team trained President Obama as a community organiser, the IDeA draws our attention to the need to rethink the relationship between local authorities and their citizens in much the same way as Sir Derek Wanless framed the relationship between the NHS, patients and the public.

The opening lines of Charles Dickens’ novel, *A Tale of Two Cities*, begin: “It was the best of times ... it was the worst of times”. Despite the apocalyptic talk about the global economy, the human species has never had as much understanding of the world around it, nor ability to influence it. Our weakness remains our ability to mobilise ourselves to address the great issues of sustainability and social justice. It is my view that local government could once again lead the way.

**References**


McKeown, T. (1976), *The Role of Medicine: Dream, Mirage or Nemesis*?

John R. Ashton CBE has always striven to connect academic and service public health with political and social action for health improvement. After 13 years as Regional Director of public health for the north west, he retired from the civil service in 2006. In 2007 he took up a new position as director of public health and county medical officer for Cumbria. He was a founder member of the UK Public Health Association and was instrumental in the establishment of a North West Public Health Association.
The fall out from the banking crisis for the public sector is estimated to mean about 15% of savings will be needed over the three years from 2011/12. Primary care trusts (PCTs) and councils will be grappling with what this will do to health and social care services. In my council this could mean finding total savings of £21m for adult and community services. One of the main challenges will be to decide whether those people with the most acute or intensive needs should be protected at the expense of those with lower level needs. For example, those who are supported currently through healthy living and wellbeing initiatives and services.

It is perhaps tempting to focus on prevention services as benefits may be a long way off for the health and social care system. Also, they can be portrayed as less essential services. Worcestershire County Council has invested over £2m in prevention services for the past five years and we were a first phase Partnership for Older People Project (POPP). Should we cut this funding, as opposed to funding for people who need intensive personal care, such as those with dementia or people with severe learning disabilities?

**Profligate public sector**

One answer, of course, is that efficiencies should be the solution. Cuts won’t be necessary at all if only the profligate public sector would match its wise private sector colleagues. Well, in my own directorate with a budget of £141m in 2009, we saved (from efficiencies and cuts) not just the £6m required by the first two years of the council’s medium-term financial plan, but a further £4.8m – making nearly £11m in total. We understand the meaning of efficiencies and savings and we have produced the goods. Our scope for further efficiencies is limited. We have been looking at this very vigorously over recent months in preparation for 2011/12, and it is clear that a measure of cuts will have to happen. The size and nature of these, as well as further efficiencies and service reform, will be determined through the political process for the whole of the council’s services.

**Predict and prevent**

So should any cuts that are finally identified and approved start with prevention services? The government’s
policies would seem to indicate a resounding “no” as the answer. The NHS Operating Framework 2010/11 and the companion document From Good to Great (Department of Health, 2009a, b), place a renewed emphasis on the place of prevention services within the NHS – a shift from “diagnose and treat” to “predict and prevent”.

The National Evaluation of POPPs found that for every extra £1 spent on the POPP services, there has been a £1.20 additional benefit in savings on emergency bed days. Furthermore, there was a 29% reduction in the use of accident & emergency departments by those using the POPP services. Reductions were also seen in physiotherapy/occupational therapy and clinic or outpatient appointments with a total cost reduction of £2,166 per person.

Worcestershire’s POPP project demonstrated an improvement in health status and quality of life over the two years 2006/08. This manifested itself in reduced social isolation and greater social interaction and “community spirit”. There was some evidence that the project reduced pressure on intensive services. Therefore quality of life improvements were noted alongside health gains.

The Marmot review identified that only 4% of the NHS budget is spent on prevention and that: “If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2bn per year to nearly £5bn in 2025”. It goes on to state that: “Wellbeing should be a more important societal goal than simply more economic growth. Prominent among the measures of wellbeing should be levels of inequalities in health” (Marmot, 2010).

**Balance the need**

A recent Audit Commission report (2010) looked at the financial challenge for councils of an ageing population. It was clear that “councils and partners should co-operate to tackle the main causes of social care need: poor housing and environment; health and mobility problems; breakdown of social support; and social isolation”. The report supported the use of early intervention to improve wellbeing and save money: “Councils must balance the need to provide social care and to support active ageing. If care service provision is simply increased alongside population growth, public spending on care services could nearly double between 2010 and 2026. Private spending on social care would increase from £5.3bn to £23bn over the same period, if trends in means-testing and self-funding continue”. The report gives case examples of where telecare and supported living schemes have led to savings through reducing the use of care homes and reducing intensive care at home services. Many further examples are included in another report: Use of Resources in Adult Social Care (Department of Health, 2009c).

Thus, the evidence and government policy is firmly behind early intervention and prevention.
Conclusion
As PCTs and councils plan for 2011 and beyond, there should be a rigorous assessment of the current position on prevention/early intervention services and what role they can play in both saving money and improving the quality of life of our citizens. The temptation will be there to concentrate on people with the highest needs at a time of ever-tightening resources. This would be short-sighted. However, the question still remains as to whether savings of around 15% over the three years from 2011/12 actually mean that the capacity to “protect” prevention services is simply not there due to the size of the savings required.

Can and should prevention services survive? This challenging context should prompt us all to at least ask the question of ourselves and partners. How much is quality of life just as important as targeting resources at those with the highest needs?

Eddie Clarke has been Director of Adult & Community Services, Worcestershire County Council since 2007. He started work as a social worker in the 1970s. His career spanned both children’s and adult social care before he moved to a joint health and social care post in Worcestershire in 2001

References
The UK has long been recognised as a multiethnic society. Latest estimates from the Office for National Statistics indicate that around 11% of the population of England and Wales identify themselves as belonging to a non-white ethnic group, and close to 16% to an ethnic group other than the majority “white British” category*. The increasing diversity of our population is clearly evident in major cities such as Sheffield where I live and work. There is a growing range of ethnic identities, languages, religions and migration circumstances and a rising number of people claiming a “mixed” ethnic heritage. Clearly, there is much to celebrate in the emerging “super diversity” of our population. However, ethnicity is also one of the major social divisions in modern Britain and ethnic identities have important implications for wealth, health and wellbeing.

Understanding inequalities
While information is still patchy, we now know much more about the health of minority ethnic populations than we did 10 or 20 years ago. Health patterns are complex but national surveys and local studies show some consistent patterns. Of particular concern are very high levels of poor health and chronic health conditions (particularly heart disease and diabetes) reported by Bangladeshi and Pakistani people and to a lesser extent black Caribbean, black African, white Irish and Indian people. This heavy burden of ill-health is reflected in the high levels of work incapacity and caring that are also reported by Bangladeshi and Pakistani households.

There can be no doubt that poor socioeconomic status is a major force in the lives of many minority ethnic people in Britain. It is also clear that these major inequalities in health are, in large part, linked to social and economic disadvantage operating at both an individual and a neighbourhood level. A wealth of evidence shows that black and minority ethnic individuals and households are disadvantaged relative to the white British majority in terms of income and poverty. Pakistani and Bangladeshi groups stand out as being particularly badly off, but black African and black Caribbean groups also do much worse than the white British. The Indian and Chinese groups tend to have
employment levels and earnings closer to the majority white British, but overall prosperity is still lower for Indians due to larger family sizes. Black and minority ethnic people are also disproportionately concentrated in deprived neighbourhoods. Sophisticated analyses (that have explored the multiple dimensions of economic deprivation faced by minority ethnic groups) suggest that a large part of the health differentials observed is the product of underlying economic inequalities.

This is not the whole story, however, and other factors also demand attention. Socioeconomic deprivation inter-relates closely with racial exclusion and discrimination across the life-cycle. Health outcomes of some minority groups are worse than would be expected on the basis of their socioeconomic circumstances alone and a growing body of evidence suggests that the direct and indirect experience of racism in everyday life is an important contributory factor ( Nazroo, 2003 ). Contrary to popular stereotypes, minority ethnic people may also suffer higher levels of social isolation and have less social support than the majority white British, particularly if they are newer migrants to the country. Importantly, too, it is clear that despite our strong legal framework and numerous policy directives, health services frequently fail to achieve equitable outcomes and high levels of satisfaction for minority ethnic patients. Of particular importance is the growing evidence of differential access to key primary and secondary preventive interventions including: smoking cessation services; cancer screening; and some treatments for heart disease. Even the most obvious services designed to minimise ethnic inequalities in access, such as interpreters, are under threat in an era of tightening public spending.

**Tackling ethnic health inequalities**

The picture I have painted suggests that there is much that can be done by local authorities to address the excess burden of ill-health suffered by some minority ethnic communities. Action is particularly warranted in these challenging economic times since members of minority ethnic groups have been found to be exceptionally sensitive to recession in terms of non-employment and material disadvantage. This vicious circle of disadvantage may well lead to a further exacerbation in the levels of poor health among some minority groups ( Berthoud, 2010 ). I would suggest that measures to ensure good take-up of welfare benefit and tax credit entitlements are important as are interventions to support people through periods of enhanced psychological stress associated with financial hardship and job losses.

More generally, there is a crucial need to ensure that all work on health inequalities is properly responsive to the needs of our diverse communities. I have been disappointed to see that, despite sustained commitment to tackling health inequalities within UK health and social policy, consideration of ethnic inequalities has been very limited. Understanding and addressing ethnic inequalities in health cannot be portrayed as an additional detail. Rather, sustained attention to ethnic diversity and inequality must be part-and-parcel of the mainstream health inequalities' agenda.
This is because the causes and consequences of socioeconomic deprivation inter-relate closely with processes of racial discrimination and disadvantage, thereby demanding particular responses. There is compelling evidence that, in the absence of explicit attention, the needs and experiences of minority ethnic individuals and communities are overlooked by those who design, deliver and evaluate interventions aimed at enhancing wealth, health and wellbeing.

We must tackle the systemic factors that persistently reproduce inequitable experiences and outcomes in public services for minority ethnic people, including poor communication; failure to address issues of most concern to minority people; a lack of visible minority presence among staff; dismissive and disrespectful attitudes and behaviour by staff; stereotyping and homogenising of minority ethnic needs; feelings of exclusion and mistrust on the part of minority clients; a lack of cultural sensitivity in service provision; and short-term, vulnerable funding.

It is particularly important to note that the types of “up-stream” interventions recently advocated by the Marmot review (such as SureStart) have had limited success in engaging with and meeting the needs of minority ethnic communities (Craig et al., 2007). Furthermore, such interventions seem unlikely to have much effect on the outcomes for minority ethnic individuals and families unless we also tackle structures of discrimination that
persist within the education system and labour market.

It is not all doom and gloom, however! There are areas of good practice and opportunities for learning from the experiences of those who are taking ethnic health inequalities seriously – the Race for Health network of primary care trusts (see www.raceforhealth.org) is one such example. However, the UK needs a far more mainstreamed approach to tackling ethnic inequalities in wealth and health, where the entitlements of minority ethnic individuals to equitable outcomes are not questioned but are rather addressed urgently as a matter of social justice.

*I have used the ethnic categories employed in the 2001 Censuses of England and Wales throughout this essay for consistency with other sources.

References
Craig, G. et al. (2007), Sure Start and Black and Minority Populations (DfES, London).

Sarah Salway is Reader in Public Health and leads the ‘Inequalities, inclusion and public health’ research cluster within the Centre for Health and Social Care Research at Sheffield Hallam University (SHU)
Manchester has been transformed dramatically in the last few decades. The city has experienced significant economic growth and led groundbreaking urban regeneration. Manchester has re-established itself as a major international city, and is a key economic driver for the Manchester city region, the North West and the UK. In December, Greater Manchester signed a city agreement with government and we have now agreed to establish a combined authority which will give us new powers over economic development, employment, transport and skills.

Although the opportunities for a better quality of life are now there, they are not being taken up by all our residents. There are still too many people in Manchester unemployed or not working and in receipt of incapacity benefit or income support benefits. Schools’ results are improving but fall behind the national average, making it less likely that all Manchester’s young people will be able to benefit from jobs on offer, and to realise their aspirations. Too many people suffer from preventable ill health, causing men and women to die earlier on average compared to other parts of the country. Although the economy of the city has been transformed and the population is growing, like the rest of the UK the city has had to cope with the economic downturn.

Part of our response to this is, working with partners, our local Wellbeing Programme which focuses on three areas:

- Increasing aspiration through the progression of apprenticeships.
- Fostering resilience through emotional wellbeing in schools.
- Health and employment.

For the third of these we have undertaken a detailed analysis of the impact of the recession on health to ensure that we target services effectively. We have seen a significant increase in the prescribing of antidepressant drugs over the past year with the greatest increase in those areas that already have the poorest health outcomes. In addition we predict that if we do not intervene early enough to address the psychological aspects of
becoming unemployed the estimated cost to local health services over the next few years will be over £16m. We are developing innovative approaches to respond to some of these problems so that health inequalities within Manchester do not get wider. We have recently attracted funding from the Department of Health and FA Premier League to deliver our health trainer programme to young men out of work. The scheme is now underway and builds on the strong reach of our two famous football clubs with the target audience.

**The scale of the response**

Our city region status also allows us to bring together frontline services to ensure the scale of the public sector response is sufficient to make a real impact in priority wards. In Ardwick, for example, staff from Job Centre Plus, NHS Manchester, council departments and voluntary and community groups will work together to provide services in a different way that better meet the needs of individuals and families. There will be a greater emphasis on social prescribing in primary care (for example meaningful activities and work as part of recovery), more preventative health programmes for children from Sure Start centres (for example immunisation and oral health) and lifestyle services for adults that address the major risk factors of smoking, alcohol, diet and physical inactivity. This is because we know that every 1% increase in unemployment sustained over a long period can lead to a 2% increase in premature deaths from heart disease, cancers and cirrhosis. Therefore, improving access to stop smoking, diet and alcohol advice services is a priority. We will align council and NHS provision in relation to physical activity so that people on disease registers are offered tailored packages of support by our leisure centres. We will also utilise our library services to enable people to get good information about managing their health conditions better, building on our successful “health matters” project.

In the last decade Manchester has moved off the bottom of the life-expectancy league tables for both men and women and has narrowed the gap with England. This is a move in the right direction, but we want to see even faster progress in the next 10 years. We will need to make this progress against a backdrop of tighter public finances and the ongoing impacts of the recession. However the city council, by exercising its strong leadership role across all public sector agencies, will ensure that there is a balanced focus on people and place and we really do deliver “more for less”.

Sir Richard Leese is Leader of Manchester City Council. He was Deputy Leader from 1990 to 1996 having previously chaired the Education Committee and Finance Committee. His political interests include the links between economic development and social policy, developing open democracy and the community leadership role of local authorities; and the role of cities in creating a sustainable future.
The late Sir Donald Acheson, the chief medical officer for the UK from 1983 to 1991, defined public health in 1988 as "The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". Now more than ever, in the face of an almost overwhelming economic crises and an ailing ecological infrastructure, that last phrase “through the organised efforts of society” comes into its own.

Health inequalities, the focus of the Acheson report, have continued to increase, even through the so-called boom years of economic growth experienced in the very first years of this century (Acheson Report, 1998). In 2010, we have the Marmot review identifying the social gradient of health and concluding that we as a society have not only to address those deepest and most entrenched of health inequalities but must seek to counter the health detriment evident throughout the socio-economic scale (Marmot, 2010).

So if health inequalities deepened during the boom years, what now during the economic lean times?

We need a radical review of the locus of public health, placing the responsibility firmly across government at the national, regional and local levels. At the local level, this would translate into a genuine partnership between the local authority, the primary care trust and environmental public bodies, plus of course the voluntary sector. This partnership would work seamlessly towards achieving the social, economic and environmental conditions that generate health and wellbeing as their natural outcome.

This partnership would need to engage the communities with whom it works in a new and creative dynamic, seeing them as co-producers of health and wellbeing at both the individual and community level. Professor John McKnight (Northwestern University) has shown the restorative effects of the energy released by working with communities on a "glass half full" rather than "a glass half empty" approach. This is done through identifying and working with the many assets manifesting in communities, rather than assessing and reducing the needs. The important differences between the community-building model and the social services
model are explained in the table (see below).

These concepts build on the work of Robert Putnam who showed that social capital is key to the health and wellbeing of communities (Putnam, 2000). In the UK in 2004, the then Health Development Agency reported that "Strengthening connections between communities, and extending those connections outside existing community and organisational boundaries, reduces health inequalities between communities because they gain power and control over the decisions that affect their lives".

However, before organisations learn to work together effectively they cannot make the leap to engaging with communities in this new and liberating manner. The current economic recession coincides with waves of new thinking about the decentralisation of power, localism etc. Total Place is one such example. Taking a whole area approach to public services, the Total Place initiative has involved 34 PCTs across the pilots, mapping around £82bn of public expenditure and identifying significant savings along the way. The Total Place findings stress the importance of data-sharing in the collaborating organisations and proposals have been put forward for "standardised partnership agreements" and "single gateways" for data collection. However, according to Peter Gilroy of Kent County Council (2010), if society means business about building upon the lessons learned: "It [Total Place] means developing new behaviours and attitudes across the public sector both in central and local government, working laterally across agencies not thinking in vertical lines. It means changing the way we train people and seeing this journey over the coming years".

The UKPHA is working in the north west of England with local authorities, PCTs and the major energy companies developing unique partnerships and data-sharing processes to address the escalating impact of fuel poverty on vulnerable populations. Winter excess deaths (currently approaching 40,000 a year) are expected to soar as fuel prices rise, the population ages and incomes are

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<th>Community-building model</th>
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<td>Focus on assets</td>
<td>Focus on needs</td>
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<td>Builds from opportunities</td>
<td>Responds to problems</td>
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<td>Investment orientation</td>
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<td>Emphasis on associations</td>
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<td>Focus on community</td>
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<td>Goal is empowerment</td>
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reduced. Alongside this excess mortality, cardiovascular and respiratory diseases increase and are exacerbated, and the falls rate among the elderly rises (Department of Health, 2009). The suffering which lies behind such grim statistics demonstrates health inequalities in their stark reality and illustrates the inextricable links between poverty, ill health and poor housing.

The UKPHA’s work in the north west is showing that we can really set about addressing health inequalities if the professionals and agencies involved are prepared to work across boundaries, outside of their professional territories and with a genuine desire to bring about change.

What is true for fuel poverty is true for almost all of the other major public health issues. We must learn to work together and with communities in new and different ways. The chronic disease burden predicted by Derek Wanless (2002) as likely to overwhelm the NHS unless society makes radical changes in lifestyle and culture, will only be lifted if public health is recognised as being everybody’s business. As Derek Wanless later stated in his 2004 report “most people who deliver good health do not even have health in their job title”. Partnership between and within organisations based on trust and mutuality and the equitable distribution of resources, whether human or financial, will be a major challenge for us all. But it is the only way that we will achieve Sir Donald Acheson’s aspiration of “preventing disease prolonging life and promoting health through the organised efforts of society”.

References
Department of Health (2009), Health & Winter Warmth Fact Sheet (London).

Angela Mawle is Chief Executive of the UK Public Health Association (UKPHA). Her career has encompassed the true breadth and diversity of public health ranging from frontline health service delivery, work in communities around sustainable development planning, through to academic environmental sciences.
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The Citizens Advice service in England and Wales provides free, independent, confidential and impartial advice to everyone on their rights and responsibilities. Between April 2008 and March 2010, Citizens Advice Bureaux (CABs) helped more than four million people, advising on over 13 million problems. CABs are continuing to see large numbers of people struggling to cope financially after losing their job or having their working hours reduced.

Citizens Advice is at the front line in recognising the increased need for advice brought about by the recession, dealing with 9,500 new debt problems every working day, increasing at an annual rate of 25%. We secured £15m from the government to extend local CAB opening hours, train more volunteers and provide self-help materials from February 2009 to the end of September 2010. The response from many local authorities has been to increase funding to CABs and in-house welfare rights teams. However, some local authorities have reduced funding to the local CAB. This is an understandable reaction to the budgetary pressures that authorities are under but can cause significant disruption to advice services and leave many people without access to the help they desperately need – much of which is delivered by locally-based volunteers, supported by paid staff.

The Citizens Advice service is made up of 390 charities throughout England and Wales; they are separate legal entities providing advice from over 3,300 locations; all of which are members of Citizens Advice, the membership organisation for bureaux. Local bureaux are funded from a variety of sources, including local authorities, primary care trusts, the Legal Services Commission, corporate and charitable foundations. An increasing amount of funding is channelled through Citizens Advice itself, which then contracts with the local bureaux to deliver services. Citizens Advice is funded by the Department for Business, Innovation & Skills, other government departments, corporate and charitable trusts and foundations.

**Debt**

Helping people with debt, especially those facing the threat of having their
homes repossessed, benefit and employment problems and promoting financial capability are all part of the everyday work of CABs. The recession has increased the demand for debt advice and provided an opportunity to increase partnership working with local authority partners. Each local situation requires an approach that matches local circumstances and, as a charity rooted in local communities, we are in a unique position to map out and seek solutions to the recession with local authority partners. Initiatives have included a leaflet about Citizens Advice sent out with council tax reminders. We have distributed 645,550 self-help debt packs to frontline council staff and we are operating a court desk in 63 courts aimed at tackling threatened homelessness as a result of mortgage or rent arrears.

Debt and benefit issues make up over 60% of our work. The increase in demand for our services is mirrored by a National Audit Office report, which found that advice agencies in the UK had a 28% increase in demand between July 2008 and July 2009 (NAO, 2010). Debt is not just a question of income and expenditure. Many vulnerable people lack the skills and confidence to manage their money. Giving people the tools to manage money is an important part of our work and helps prevent people falling into a vicious cycle of debt and despair. Reducing defaults on rent and council tax payments reduces demand for council-led social services and housing, saving council funds:

South Derbyshire CAB delivered financial capability training to staff based in the council housing department. Council staff were used to dealing with tenants in arrears but found it challenging to distinguish between those unable to pay and those who refuse to do so. Previously the bureau received information only days before an eviction and the training has resulted in early referrals to the bureau (South Derbyshire CAB, chief executive).

Health
The recession is having a detrimental impact on health and wellbeing. The Marmot review (Department of Health, 2010) found that having insufficient money to lead a healthy life is a significant cause of health inequalities. Research by Jenkins et al. (2008) found that one in four people with mental health problems is also in debt. Stress can also make it more difficult for people to help themselves get out of the cycle of debt. A sample of people visiting CABs with debt problems found that 60% had not tried to negotiate with their creditors as they were too stressed to do so:

Halton and St Helens CAB found that when people first approached the CAB for help, 90% of service users identified themselves as being stressed/very stressed. However, by the time the case was successfully concluded, that figure had dropped to just 11% (Halton CAB, chief executive).

In 2009/10, Berwick CAB received council funding of £30,000. In addition to this, the CAB levered in an additional £320,000 of funds which mainly went towards salary costs for local people working in the CAB. The CAB generated over £1.7m in incomes and debt written off giving a return for local citizens of
£56.66 for every £1 of the local authority investment. [This is based on lump sum benefits payments, payments of confirmed benefits for the remainder of the financial year, debts written off, recovered wages and payments to clients following resolution of employment disputes.] (Berwick CAB, chief executive.)

Joint work across services
Exploring solutions to the recession in partnership with local people, Calderdale CAB developed the concept of ‘problem noticers’ where, by virtue of their position, frontline workers such as health visitors, family link workers and community members are well placed to identify individuals or families struggling to cope and would benefit from support (Calderdale CAB, chief executive).

Problem-noticing skills training has been funded by Calderdale Council Economic Taskforce to provide information and knowledge to frontline workers and community members as to which agencies are best placed to help with enquiries. The aim is to provide a network of advisers across Calderdale to add value to existing services by pro-actively signposting people to the appropriate agencies to help resolve their problems.

The future
As the country turns towards recovery, the human cost of the recession for those left behind can be high. It can take time for individuals and communities to recover from job losses and major changes in economic circumstances. Timely advice and support is less costly for a local authority - and society - than the estimated £16,000 cost calculation provided by the Department of Communities and Local Government (DCLG) of the repossession of a vulnerable household (DCLG Homeowners Support Package, 2008). This is a cost associated with housing benefits payments that would be paid to the household to house them in temporary accommodation and then in the socially rented sector. It is vital that measures are put in place by local authorities to increase advice provision and so shield people from the worst effects of the economic downturn.

As the demand for advice increases CABs have sought to work in different ways to ensure that as many people as possible receive the help that is most appropriate to their need. Greater efficiencies are being achieved through the use of volunteers and administration staff in CABs. Our vision is that, by 2014, our clients will have more choice about the way they can get information and advice from us. Our Adviceline, a single telephone number covering our entire service, will enable callers to be advised on the spot or quickly referred to bureau or another agency for help. CABs continue to
provide effective support for citizens, and provide excellent value for money for authorities.

References


Elizabeth Ladimeji has been Head of National Partnership development at Citizens Advice since 2008. She was formerly head of partnerships at National Council for Voluntary Organisations and has experience working for national and local voluntary organisations both as a staff member and a trustee.
In the recent national elections, politicians from across the political spectrum made their case as to why they were best placed to lead our country for the next five years. Writ large in all their appeals to citizens was the economy and how they had the most innovative ideas to secure a recovery. The debate was important and the new government’s approach will clearly set the tone for how we help communities through difficult economic times both now and in the future.

Although this national debate was important, we must not forget the vital role that local government plays in difficult economic times. During the boom years of the late 1990s and 2000s, our local knowledge and expertise was critical to ensuring that regeneration programmes worked for our communities, that local businesses grew, that citizens had the right skills to access employment and that barriers such as poor health and low aspiration were tackled. When the economic downturn began to hit, local government responded quickly to a rapidly changing environment. We refocused programmes and reached out to businesses and citizens – to ensure they had all the support they needed to weather the global recession.

**A three-pronged approach**

Local government’s success in economic affairs has been due to the realisation of three key principles, which we in Lambeth have lived by:

- **Clear leadership**: Having a clear long-term strategic direction for the borough – and having the confidence to stick to it even if the journey to realising it becomes more difficult.
- **Awareness of context**: Recognising that changes in the local environment may mean that while your long-term vision is right, your approaches to realising it must change. Successful councils do this intuitively and by design.
- **Asking ‘what’s next?’**: A truly successful local authority must respond to its immediate environment but not be sidetracked by it. As a community leader, local government must be looking “over the horizon” to see the first signs of new opportunities and new ways to meet citizens’ needs.
Clear leadership
Even before the recession, many of Lambeth’s citizens were facing difficult economic times. The borough has had a comparatively lower employment rate for a number of years and within our deprived communities unemployment was a key cause of poverty, inequality, poor health and high crime. The council, working with Lambeth First, our local strategic partnership, made a conscious decision to break this cycle by setting a clear long-term focus on tackling worklessness through our sustainable communities strategy and local area agreement.

Our clear leadership and clarity of focus on worklessness was having an impact prior to the recession. Overall, employment was rising, attainment and skills levels were improving and people’s aspirations were being raised.

Awareness of context
When the full effect of the recession hit the UK, our goal of eradicating worklessness in Lambeth seemed, to some, to be overly optimistic – even hubristic. However, as a community leader the council recognised that, regardless of the immediate challenges posed by the recession, the need to tackle worklessness remained critically important to securing improved wellbeing for our citizens. With our partners, we therefore made the conscious choice to hold to our course.

Our strategic clarity, though, did not blind us to the need to respond to the changing context on the ground. We re-evaluated our approach to helping people through difficult economic times and developed a borough-wide economic recovery plan. This focused on new activities to support residents, communities and businesses and brought various schemes under one strategic board. This has ensured that there is coherence to our entire programme.

In delivering this plan, we have set up a business loan fund (worth £400,000 in total); a business financial advice desk, which provides clear and concise signposting information; and we are ensuring that invoices from small and local enterprises to the council are paid within 10 working days. We have also supported our residents by expanding our debt advice service and have rolled out a home energy advice service to improve energy efficiency/help residents to make improvements to their home.

This plan also draws in existing activities such as our “Every Pound Counts” campaign that provides benefits advice and guidance to key vulnerable groups within the borough. Over £10 million has been claimed since the scheme first started in April 2007. At a wider partnership level, we have worked through Lambeth First to secure over £2m in Future Jobs Fund (FJF was announced in the 2009 national budget and seeks to create jobs for long term unemployed young people and others who face disadvantage in the labour market). The funding from this scheme will enable the creation of 355 new full-time and part-time local jobs.

Asking “what’s next?”
Our work over the past 18 months has helped steady our local economy, supported citizens through these difficult times and preserved our long-term focus on tackling worklessness. All this is very positive,
but our journey is not at an end. The severe recession was a mere preview of the period we are about to enter. With a sky-rocketing public sector deficit, local government will be under enormous pressure to cut budgets and services.

As the best-performing part of the public sector, local government will respond to this challenge, as it has so often in the past. However, slashing budgets and cutting services will hurt our most vulnerable communities if it is not guided by a clear sense of purpose. What is therefore needed is a clear sense of what 21st-century public services are for – the relationship between citizen and state, the modern principles on which they need to be based and a radical new approach to how we can live these principles through service delivery. Gaining clarity on these issues will not only guide how we reduce spending, it will also ensure that we can continue to help our communities through the difficult economic times that will occur in the future.

Local government, thinktanks and political parties are already setting out new and exciting ideas. Whitehall's positive embrace of the Total Place initiative provides another real opportunity to take forward radical and creative approaches to service delivery. All this debate and discussion can only be a good thing, but this debate on its own is not enough. As the chief executive of a democratically-accountable public body, I know that Lambeth Council has an important role in shaping the debate locally so that these ideas and proposals are right for Lambeth and our sub-region. Lambeth Council is already playing an active part in this debate and we have set out our ideas on moving to a co-operative council model. We are currently developing our thinking on this further and are working with residents and partners.

Lambeth's story over the past few years is similar to many of our contemporaries and shows the role local government can and must play helping people through difficult economic times. Local government is ideally placed to tackle long-term challenges and lead the refocusing of services when the "facts-on-the-ground" radically changed. It is also ideally placed to always looking over the horizon for the next challenge. As the new national government settles in, I strongly encourage the sector to continue this leadership role. Building on our success in tackling the immediate impacts of the recession, we need now to grasp the opportunity to reshape and redefine our public services – so that they are there the next time citizens enter difficult economic times.

Derrick Anderson CBE is Chief Executive of Lambeth Council. He was chief executive of the City of Wolverhampton Council for 10 years.
Readers will be familiar with the idea that community-level resources are important for the health and wellbeing of residents. There is a substantial body of evidence showing that living in a more deprived residential community is linked to greater risk of poor physical and mental health, including coronary heart disease, psychological distress, lower birth weight and higher risk of preterm delivery, and mortality (for example Pickett and Pearl, 2001; Riva et al., 2007).

Certain sections of the residential population can be more affected by community-level factors. In particular, the health of those who are not in employment is more closely linked to community deprivation than is the health of those who are employed.

Figure 1 (below) is based on data from around 10,000 adults who took part in the Department of Health’s annual Health Survey for England and shows that people living in more deprived areas were more likely to report that their health was poor. Comparison of the bars on the left and the right shows that this association is stronger and larger for those who were not in paid employment.

These differences are not confined to those who are or are not in employment. Using data from the Whitehall II study, a similar picture emerges. The Whitehall II study is an on-going survey of over 10,000 British civil servants who worked in London when the study started in 1985. By definition, all participants in the study...
were working initially but they were drawn from across the different grades of employment within the civil service. Figure 2 (below) shows no clear link between area deprivation and poor mental health for those in higher grades (marked high SES, blue bars). However, for people in lower grades who have lower incomes and less prestigious jobs (marked low SES, yellow bars), there is a clear link between poor mental health and area deprivation (Stafford and Marmot, 2003).

How does this link between residence in a deprived area and health play out over time? There are clearly challenges to studying this because of the costs and logistical difficulties in following people who are residentially mobile and communities which are changing in character. However, a handful of studies have attempted to do so. Using information from Whitehall II study participants who did not move over 10+ years of follow-up, we examined mental and physical health between 1991 and 2004. In 1991, people living in more deprived areas had poorer mental and physical health than their counterparts living in less deprived areas who were of a similar age, gender and personal socioeconomic circumstances.

Throughout the course of follow-up, there was a general improvement in mental health. This is in line with many other studies showing that mental health gets better during adulthood up to the age of 60 or so. However, this improvement was not seen in the most deprived areas. Those people living in deprived areas had poorer mental health initially and the gap between those in more and less deprived areas widened over time (Stafford et al., 2008).

What are the implications of this evidence? Both personal and community-level socioeconomic resources are linked to health. To the extent that a period of

**Figure 2**

% with poor mental health by deprivation of area

<table>
<thead>
<tr>
<th>Deprivation Level</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with poor mental health</td>
<td>13%</td>
<td>17%</td>
<td>28%</td>
</tr>
</tbody>
</table>

- Low Deprivation
- Moderate Deprivation
- High Deprivation
recession results in increased numbers of people out of work and reduced opportunities for secure and well-paid jobs, we would expect that a recession would have consequences for individuals and for communities and, ultimately, for health. Academic research is seeking to identify the most important community-level characteristics that relate to health, including the built environment, social capital and local services and amenities, as well as what works for community regeneration. This is challenging and requires on-going investment and collaboration between practitioners and researchers developing the evidence base.

We have to situate this work within the broader field of research on health and social inequalities, which has a long and rich tradition in the UK. In a society where there are large inequalities in education, income, occupation and other socioeconomic factors, there will be correspondingly large inequalities in health. There will also be inequalities in the material and social resources available to different residential communities (Dorling et al., 2009).

In summary, it is clear that both personal and community deprivation contribute to poorer mental and physical health and that poorer individuals within deprived communities experience double jeopardy. Initiatives to tackle health inequalities will need to address an individual’s socioeconomic situation but should also consider the way in which the residential environment magnifies the effect of personal poverty.

References

Mai Stafford is a senior lecturer in the Department of Epidemiology and Public Health at University College London. She is looking at the ways in which neighbourhood environments might influence health and well-being and assessing the impact of area-based initiatives.

Mel Bartley is a professor in the same department at UCL. Her current research interests include the effect of processes over the life course on social and health advantage, disadvantage and resilience, and how these are influenced by economic and social policies.
Communities and community life can be hard hit by economic recession. People have to live on smaller incomes, small businesses dwindle and government support is reduced. Beyond the financial repercussions, reduced support for community activity can leave citizens with little means to collectively tackle local problems, and have their voices heard by government. As times get tough, tensions can also run high, pulling people farther apart or into conflict. Community strength and cohesion fall by the wayside, and democracy and quality of life suffer. But we do not have to go down this path. There is an opportunity in the UK to help communities to help themselves through these difficult times. And we can do it while relieving the strain on the public purse. It depends on collaboration and innovation: collaboration among local people themselves, and between local people and government, and innovative approaches to funding and service provision. However, to do this communities and government must be willing to invest in an approach that brings people together, improves the efficiency and sustainability of our services, and builds the capacity of citizens and government to work together to get the job done. For these reasons, the current economic climate makes it vital to pursue a community development approach.

**A community development approach**

In 2006, the Community Development Foundation (CDF) led a coalition of organisations, practitioners and academics in defining community development as “a set of values and practices which plays a special role in overcoming poverty and disadvantage, knitting society together at the grass roots and deepening democracy” (*The Community Development Challenge*, 2006). Four years later, as we struggle with recession, we will depend on this approach to support hard-hit individuals and communities, tackle the big issues through teamwork, and strengthen our decision-making processes now and for the future. In CDF’s 2009 survey of community development workers and managers, there was a strong feeling that economic hardship may lead to renewed enthusiasm for collective
action – of citizens, community groups, community development workers, and government alike.

**An inexpensive and sustainable resource**

Over the years, CDF has managed numerous small grant programmes to support local community groups. These groups continually astound us with the incredible reach and impact they can achieve at relatively low costs. We are currently seeing the groups funded by our Grassroots Grants programme reach hundreds of beneficiaries, and they are doing this with an average grant size of less than £2,500. What is more, by using a community development approach in our grant-making, we have helped funded groups to become more and more self-sustaining. When tracking the health of organisations funded by a former grant programme, the Neighbourhood Support Fund, we found 54% of organisations had an income of under £200,000 before the start of the programme. Since the end of the programme, 52% have an income of £200,000 or higher, with a considerable number having an income of £500,000 or higher.

**False economy**

We need to dispel the myth that community development is an additional expense. As budgets tighten, community development activities and workers are sometimes seen as expendable. But cutting community development budgets is a false economy. While this may appear to relieve financial strain in the short term, it weakens service development and stifies local solutions in the long run. With less money available, local government cannot afford to invest in unused or underused services. A community development approach ensures that needs are more accurately identified, services are more responsive, and overlaps of resources from different public providers are avoided.

**Informing better service development**

A community development approach can build the capacity of citizens to act as a collective, maximising their impact and giving service providers a clear point of contact within the community. When we ran the Connecting Communities Plus, community grants programme, groups received funding to tackle cohesion and equality issues in local communities. More than 50% of grant recipients worked in partnership with local government on service development – often advocating on behalf of historically under-represented groups. In our study of community development and migration, we came across community development workers who identified the needs of migrant communities through a series of consultation exercises, and then ran events to bring service providers together with these groups. Migrant communities had their voices heard, and service providers got a much better understanding of how to tailor their support to meet these communities’ needs. This approach also assists local public bodies explain allocation of resources to the wider public, helping to minimise potential tensions between different groups within a community.
Local support for tight budgets

An upmarket version of communal living at the Springhill Community Housing Development, around a communal house where meals etc will be cooked.
Local support for tight budgets

An upmarket version of communal living at the Springhill Community Housing Development, Stroud, where people who live here are living with 30 homes and 12 studios centered around a communal house where meals etc will be cooked.
Self-help
Where there are gaps, vibrant self-help groups often serve to enrich service provision in a local community. Our current research into community self-help (the collective ability of groups to make decisions and take direct action in addressing their communities' needs, with minimal influence from government) is demonstrating just how adept communities can be in dealing with their own challenges. Our initial exploration into community self-help has looked at groups that successfully take on a variety of local problems, from providing child care to revamping derelict buildings.

Community development workers – an indispensable resource
By building links, communication and trust between local people and service providers, community development workers help to create “engageable” communities, tailored support, expanded reach of services, and greater involvement from communities in decision-making. These experienced and dedicated professionals tread a path for frontline agency workers to connect with communities and broker relationships where they haven’t previously existed or where they are weak. The importance of community development workers is amplified in disadvantaged communities, where the need for information, sign posting and capacity building is often greater.

Communities are counting on local government
Local government has the potential to take a leadership role in promoting the community development approach. In response to our 2009 survey, community development workers and managers reported that they worked on a variety of government policy areas and agendas, guided by key national indicators such as the percentage of people who feel they can influence decisions in their locality and the level of civic participation in the local area. Managers need to be able to explain the role community development workers can play in helping their council allocate limited resources effectively and efficiently and, at the same time, promote the councils as listening bodies, honest about what can and can’t be achieved in difficult times. Elected members can also help champion the role of community development workers, each providing the other with mutual support and co-ordinated action in reaching particularly the most marginalised and disadvantaged communities. Finally, local authority chief executives are crucial in establishing a culture where the skills and values of experienced community development workers are recognised and respected, and ensuring their knowledge of a local area – the issues, opportunities and networks – can be strategically integrated into dynamic and evolving local planning processes.
Beyond cost-savings

Strengthening community development is not just about weathering storms. Whether we find ourselves in a period of recession or prosperity, community development can help us build a foundation for better public services, more self-sufficient communities, and a stronger, more representative democracy. Our communities have the opportunity to not only come out of the recession on both feet, but to come out stronger and more confident than ever before.

Alison Seabrooke has worked in both the public, private and charitable sectors. For the past 14 years, she has worked with and for communities as Chief Executive of the Community Development Foundation (2005-present), and as chief executive of Yorkshire’s Riccall Regen Centre (1996–2004). In 2003, she played a key role in responding to the Selby coalfield closure, working with government, local agencies and individuals to support, train and redeploy 2,000 mineworkers, resulting in a low uptake of Job Seekers Allowance.
For the past three years, the Young Foundation has worked with the IDeA and three local authorities – Hertfordshire County Council, Manchester City Council and South Tyneside Council – as well as Lord Richard Layard from the London School of Economics (LSE), on the Local Wellbeing Project. During this period, “wellbeing” has moved to the forefront of public policy, with all the main political parties exploring how government can help its citizens to be happier.

Finding practical ways to increase wellbeing and resilience

At the local level, the Local Wellbeing Project has spurred innovation and fresh approaches to priority issues, and has generated a body of learning about how national policies can be taken forward. The biggest element of the project has been its work in schools through the UK Resilience Programme (UKRP) with 11-12 year olds (year 7s), aimed at increasing children’s emotional resilience and coping skills. Evidence from the 2009 interim evaluation of the UKRP, funded by DCSF, shows that it has helped some of the children who struggle most with school.

The Local Wellbeing Project aimed to find practical – and replicable – ways to improve residents’ wellbeing. The emphasis was on subjective wellbeing: how people feel about the quality of their lives and their day-to-day experience. In the early stages we scoped the evidence suggesting that local government intervention can increase wellbeing, and mapped this onto the local partners’ priorities. Themes that emerged included work in secondary schools, targeting children going through the recognised stress point of the primary to secondary transition.

The interest of the local authority partners was in wellbeing and emotional resilience, and whether boosting these could improve achievement and classroom behaviour. It also reflected a growing concern about the number of children lacking the basic coping and life skills that enable them to concentrate, learn and benefit from their school experience. Although the UK government spends more on children than the OECD average, a 2009
European Union study ranked the UK 24th out of 29 European countries on child wellbeing.

Bringing a US model to the UK The search began for international examples, and the Penn Resiliency Program (PRP), developed and tested by Professor Martin Seligman and colleagues at the University of Pennsylvania, was chosen as the most robust and well-evidenced approach. This was used as the template for the UKRP. Partner authorities funded the work from a number of different sources including neighbourhood renewal funding and children's mental health budgets.

In the academic year 2007/08, 2000 students in 22 schools took part in the programme. Teacher training is “manualised” – with set content for each session. This means that there can be consistency between different teachers. It is taught over 18 hours in groups of up to 15 students.

UKRP aims to improve the emotional resilience of 11–13 year olds by building important life skills to enable them to deal constructively with daily problems and challenges. The curriculum focuses on cognitive and social problem-solving skills, assertiveness, negotiation and relaxation. Children learn to apply what they learn to real-life examples.

Impact on children and schools The DCSF-funded evaluation of the UKRP found a significant positive impact on depression and anxiety levels. This effect was larger for girls than for boys, for children who had lower initial scores for depression and anxiety, and for those who had not met the target levels for key stage 2 in their exams.

For our three partner local authorities, introducing the programme has been challenging. There were initial suspicions about the value of teaching “happiness”, and some early press interest centred on the cost of sending teachers to the US to train (although this was for the first tranche of teachers only and was carried out in their summer break). There have been inevitable problems caused by teacher turnover, and some schools have taken to the programme more enthusiastically than others. The three authorities are taking the work forward in different ways, rolling out training to new schools, in some cases adapting the original materials in order to meet local needs.

UKRP has proved most successful in schools where a critical mass of teachers have been trained and where senior staff have bought into the approach. UKRP supports schools to meet their statutory requirements to contribute to pupil wellbeing, introduced in 2007. It sits comfortably alongside SEAL – the Social and Emotional Aspects of Learning programme – strongly promoted by the government and compulsory for primary schools. UKRP targets individuals through a series of interventions, whereas SEAL focuses on the whole-school ethos.

The wider potential of resilience training The Local Wellbeing Project has shown that increasing wellbeing is an effective strategic aim for local government, that it can spur innovation, and has resonance in very different authorities with different populations and political control.

There is enormous potential in resilience training programmes to help people improve the strengths and
capacities we all need to manage our own lives. Programmes similar in approach to UKRP could be developed for older teenagers or primary school children, as part of worklessness programmes or as an element within a package of support for vulnerable families, young people leaving care or teenage parents. Resilience – people's ability to bounce back in the face of adversity - is a critical asset for a society coping with the long-term impacts of recession.


*Nicola Bacon is an Associate Director of the Young Foundation. She is responsible for the Young Foundation's large body of work with local government on communities, wellbeing, housing and innovation. Before this, Nicola worked briefly at the Home Office, ran an award winning homelessness prevention charity Safe in the City, and was director of policy at Shelter*
Child health
According to the World Health Organisation, progress towards improving maternal and child health has been reduced due to public spending cuts in health services. This was previously witnessed during Peru’s 1980s economic crisis, when infant mortality jumped by 2.5% - 17,000 more children died as public spending and programmes collapsed (Parker-Pope, 2008).

US projections for 2011 indicate “virtually all the progress made in family economic wellbeing since 1975 will be wiped out” due to child obesity and poor health “as the recession drives parents to rely more on low-cost fast food” (FCD, 2009). Researchers from the US-based Free University of Amsterdam found that individuals born in a recession are at higher risk for heart problems later in life and live on average 15 months less than those born in better times. Babies in poor households were found to suffer more during a recession, as families lacked access to good health care. Poor economic conditions have also been found to cause stress, interfering with parent bonding and child development. Other studies have found that recessions actually benefitted babies if parents spent more time at home – however, this generally applied to wealthier families, with savings or where one partner was still in employment (Parker-Pope, 2008).

Adult/workforce wellbeing
The Economist’s 2010 predictions estimate a 60 million increase in unemployment worldwide and more than 200 million workers at risk of joining those who live on less than $2 a day. Unemployment, poverty and inactivity can impact the health of workers and their families, and disrupt community and social relationships. Physiological impacts from unemployment and job insecurity include increased heart disease and hypertension. Psychological and societal impacts include greater ‘risk’ behaviour, such as problem drinking and poor diet, stress, increased risk of marriage break-ups; financial and debt mismanagement (Mental Health Commission Canada, 2009; TUC, 2010). Researchers at the University of North Carolina measured health in the US against economic shifts and jobless rates from 1972 to 1991. They
found that “cancer deaths rose 23%, and deaths from flu and pneumonia increased slightly. Suicides rose 2%, homicides 12%”. The 1990s economic recession in Japan found unemployed people were twice as likely to be in poor health, compared to those with secure jobs (Parker-Pope, 2008). As with children, the linkages between adults' health and the downturn are complex. There is evidence in UK, USA and elsewhere, that reduced growth can bring environmental and social benefits. For example, positive environmental health effects can result from people making less use of cars and switching to public transport, cycling and walking, resulting in reduced air pollution and improved physical health.

Global health/poverty targets
The International Labour Organisation (ILO) has reported that many poorer economies are facing severe impacts to communities’ health and wellbeing due to the economic downturn. According to the World Bank (2010), 1.2 million more children under age five and 265,000 more infants will die between 2009 and 2015. One hundred million fewer people will have access to safe drinking water in 2015 because of the crisis. Health impacts are also experienced where recruitment of migrants was falling, cutting remittances supporting families back home (ODI, 2009).

Europe’s experience
In Europe, an ageing population is placing increasing pressure on local services and the economy as a whole, posing major economic, budgetary and social challenges, including on pensions, social services, and healthcare, as well as a skills shortage in the labour market. There is anecdotal evidence that budget cuts, particularly in smaller local authorities, are impacting on social and discretionary services such as libraries, arts and leisure, which do much to support wider health promotion and address inequality. Rises in fuel prices will have greater adverse health affects on the socially disadvantaged and older people. Like the USA, there are also concerns that people are turning to cheaper and less healthy food options.

Health inequalities and our response
Inequality and access to support services are critical issues to address in response to the downturn. In 2009, the European Commission published a report on Dealing with the Impact of an Ageing Population in the EU, which indicated on health inequalities are growing. Social determinants still play a huge role in the life-expectancy of EU citizens.

Overall, there is concern that the current economic situation will impact negatively on partnership working to tackle health inequalities, as partners are forced to retrench. EU-level activities that address health inequalities are reinforcing the message that it is precisely in these difficult times that partners need to be vigilant and to act against further widening of inequality.

International responses
Responding to global concerns the World
Health Organisation’s Commission on Social Determinants of Health (CSDH) advice on health inequalities prioritises: improving daily living conditions; tackling inequitable distribution of power, money, and resources; measurement and understanding the problem and assess the impact of action.

Clearly, activities focusing on stimulating local economic development, local businesses and employment should bring important wellbeing benefits. Such work should also address migrant workers in accordance with the ILO conventions protecting migrant rights, which recognise migrants help promote economic growth and wealth creation in the countries of destination, as well as contribute to poverty reduction and development in their countries of origin.

Local government has responded to these challenges in a variety of ways. For example New Zealand’s district health boards use a combination of national priorities and local needs assessments to determine priorities for their districts and subdistricts. They use six broad determinants of health and target:

- Underlying social and economic determinants of health.
- Intermediate factors, such as behaviour, environment and material resources.
- Health and disability support services.
- The feedback effect of ill health on socioeconomic position.

Local government is central to developing and delivering various socio-economic interventions.

Community development programmes can empower people and increase feelings of control. School-based services targeting children from disadvantaged groups can develop coping skills. Other local policies, such as accessibility of bike paths, recreation, playgrounds and transport, car-free communities and programmes that support development of personal skills have a role to play. Housing policies and sustainability programmes can reduce the exposure of vulnerable groups to unfavourable living conditions, such as the Canadian Green Municipal Fund (see http://gmf.fcm.ca).

What next?

Demands on social and health care services are increasing and the current models for service provision are not sustainable, either in terms of cost or human capacity. With an ageing population, the traditional caring group (for example people who look after their parents) will become those in need of care and support and their children a much smaller support group in the population.

While there is an obvious need to exit the financial crisis as quickly as possible, sweeping cuts in public spending now are likely to have a detrimental effect on provision to those most vulnerable. Long-term reforms are needed to ensure that vulnerable groups have decent pensions, access to services and can re-engage with economies, without putting an unsustainable burden on future
generations. Better measurement of health impacts and required resources, and new forms of partnership working will also be critical to address increasing health inequalities.

The United Cities and Local Government (UCLG) association conducted a global survey of local government and the impacts of the recession in 2009, which highlighted how varied impacts have been between local areas, as well as how weak powers restrict local government’s capacity to respond to the crisis (see UCLG, 2009). National governments will need to equip local government with sufficient powers and resources to provide services effectively, according to their local priorities and needs.

Also in 2009, the UN agreed a set of international guidelines on universal access to basic services with the UCLG to ensure that social safety nets are in place. These guidelines recognise that a long-term multi-level approach is needed, one that builds greater resilience and self-sufficiency prior to future financial crises. The challenge for all countries is to deliver equal, efficient and sustainable access to social and health care services. There is much local good practice and know-how to share internationally. Now is the time for councils, health care providers and others to pull together, with the aim of ensuring that those whose health is most at risk from the downturn are both protected and empowered.

References
ILO (2009), Facing the Global Jobs Crisis – Migrant Workers, a Population at Risk.
Mental Health Commission Canada (2009), The Recession’s Impact on the Mental Health of Workers and their Families: A Global Perspective (Calgary).
TUC (2010), see www.tuc.org.uk/economy/tuc-17402-f0.cfm
UCLG (2009), The Impact of the Global Crisis on Global Governments (Barcelona).

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