

9: Health for all

We must improve the life changes of the poorest fastest, with activity prioritising prevention.

The challenge

Poor health is not a case of good or bad luck: factors associated with socioeconomic status can dramatically impact on health outcomes. As with economic wellbeing, it seems that good health is becoming increasingly a case of the 'haves' and the 'have-nots'.

In communities where there is poverty, there are also people struggling with chronic physical and mental ill health. Those that 'have not' are more likely to experience environments that are damaging to their health, such as poor living and working conditions; a lack of exposure to opportunities to build positive health outcomes; power to influence decisions about the allocation of health resources; and opportunities to enable children to start life in a way that minimises vulnerability to poor health.

Health outcomes are unevenly distributed. The relationship between geography and health outcomes is apparent from birth: for example a baby girl born in Manchester can expect to live 15 fewer years in good health than a girl born in Richmond.

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Evidence indicates health inequalities are becoming a challenge. Local authority cuts and welfare reforms have impacted some areas and groups in society more than others, and there has been a reduction in services where need is greatest.

What needs to be done?

There is, therefore a growing need to tackle health inequalities through recognition of the wider, socioeconomic determinants of health. We need to invest in approaches that seek to eradicate preventable ill health by tackling it before it starts.

National investment and policy to reduce health inequalities

Public sector cuts need to be slowed down, evidence-based, less extensive and not hit the poorest hardest. Policy also needs to recognise the interdependency of different budgets: cuts to benefits may reduce public sector spending in the short-term, but will ultimately sink more people into poverty meaning increased pressure on health budgets.

Funding allocations to combined authorities and city regions should be according to need in order to improve the health of the poorest. Localities should be given the power to control how they spend their health budget so that provision can target local priorities. This approach would allow

health inequalities to be tackled both between and within different regions of the UK.

CLES reported on the Inquiry to Health Equity for the North, commissioned by Public Health England. The inquiry panel examined health inequalities in the north of England to develop policy recommendations to address health inequalities.³⁰

Invest in local joined-up approaches that tackle the wider determinants of health

Delivery organisations need to invest in on-the-ground staff that develop a deep understanding of communities. Individuals and families that experience multiple needs such as reoffending, domestic abuse and poor physical and mental health should have consistent contact with a single key worker as opposed to different professionals targeting different issues. Delivery organisations need to link up with the key worker and share information to ensure the impact of spiralling problems in one area does not lead to chronic ill health.

Local approaches to health inequalities need take a wider, more holistic approach to health. This means joined-up commissioning and service delivery that understands the complex links between health and socioeconomic status.

CLES has undertaken work with Shelter³¹ which highlights the benefit of joint working and pooling resources across a range of health related services.

The full Manifesto for Local Economies can be viewed on the CLES website, [here](#).