DUE NORTH

Executive summary report of the Inquiry on Health Equity for the North

Due North: The report of the Inquiry on Health Equity for the North

Inquiry Chair: Margaret Whitehead

Executive summary report prepared by the Inquiry Panel on Health Equity for the North of England

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Aknowledgements

We thank the many people who contributed to the Inquiry's work. This Inquiry was carried out by a panel chaired by Margaret Whitehead and supported by a secretariat from the Centre for Local Economic Strategies (CLES). The review was informed by 18 policy makers and practitioners, with expertise in the relevant policy fields (see appendix 1) and four discussion papers prepared by Ben Barr, David Taylor-Robinson, James Higgerson, Elspeth Anwar, Ivan Gee (University of Liverpool), Clare Bambra and Kayleigh Garthwaite (Durham University), Adrian Nolan and Neil McInroy (CLES) and Warren Escadale (Voluntary Sector North West). This report was prepared by the Inquiry Panel supported by CLES (Neil McInroy, Adrian Nolan and Laura Symonds) and the WHO Collaborating Centre for Policy Research on Social Determinants of Health (Ben Barr). Public Health England provided financial support for the conduct of the Inquiry and the gathering of evidence but played no part in the decisions or conclusions of the Inquiry Panel.

PREFACE

Life is not grim up North, but, on average, people here get less time to enjoy it. Because of poorer health, many people in the North have shorter lifetimes and longer periods of ill-health than in other parts of the country. That health inequalities exist and persist across the north of England is not news, but that does not mean that they are inevitable.

While the focus of the Inquiry is on the North, it will be of interest to every area and the country as a whole.

This has been an independent inquiry commissioned by Public Health England. We particularly wanted and welcome fresh insights into policy and actions to tackle health inequalities within the North of England and with the rest of the country, in the context of the new public health responsibilities locally and nationally, and the increasingly live debate about greater economic balance.

I would like to thank Professor Whitehead, her panel, witnesses to the Inquiry and the Centre for Local Economic Strategies for the time, energy and commitment that has resulted in this report

PHE's own interim response to the issues and recommendations from this inquiry is published alongside this report and we will produce a fuller response at a later date, when we have had time to explore and consider the issues in greater depth. We look forward to contributing to stimulating discussion and debate with partners over the coming months.

Paul Johnstone
Public Health England
August 2014

FOREWORD

We have lived with a North-South health divide in England for a long time, illustrated by the shocking statistic that a baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in Richmond. This gap is not static but has continued to widen over recent decades. This regional health divide masks inequalities in health between different socio-economic groups within every region in England which are just as marked: health declines with increasing disadvantage of socio-economic groups wherever they live in the country.

By and large, the causes of these health inequalities are the same across the country – and are to do with differences between socioeconomic groups in poverty, power and resources needed for health; exposure to health damaging environments; and differences in opportunities to enjoy positive health factors and protective conditions, for example, to give children the best start in life. It is, however, the severity of these causes that is greater in the North, contributing to the observed regional pattern in health. It also marks out the North as a good place to start when inquiring into what can be done about social inequalities in health in this country. There may be lessons to be learnt for the whole country.

There are more pressing reasons, however, for setting up this Inquiry on Health Equity for the North at this point in time. The austerity measures introduced as a response to the 2008 recession have fallen more heavily on the North and on disadvantaged areas more than affluent areas, making the situation even worse. Reforms to the welfare system are potentially increasing inequalities and demand for services. At the same time, there are increasing calls for greater devolution to city and county regions within England. There is a growing sense that now is the time to influence how the process of devolution happens, so that budgets and powers are decentralised and used in ways that reduce economic and health inequalities.

It is against this background that the Inquiry Panel developed its' recommendations – recommendations that are based on an analysis of the root causes of the observed health inequalities. A guiding principle has been to build on the assets and agency of the North. There are plenty of ideas, therefore, about what agencies in the North could and should do, made stronger by working together, to tackle the causes of health inequalities. These are centred around the twin aims of the prevention of poverty in the long term and the promotion of prosperity, by boosting the prospects of people and places. They are also about how Northern agencies could make best use of devolved powers to do things more effectively and equitably.

The Panel is keen to stress, however, that there are some actions that only central government can take. Government policy is both the cause and the solution to some of the problems analysed by the Inquiry. The report therefore sets out what central government needs to do, both to support action at the regional level and to re-orientate national policies to reduce economic and health inequalities. There is an important role too for national health agencies, including the NHS and Public Health England. The aim of this report is to bring a Northern perspective to the debate on what should be done about a nationwide problem. We are optimistic that something can be done to make a difference and that this is the right time to try.

Margaret Whitehead
Chair, Inquiry on Health Equity for the North
August 2014

EXECUTIVE SUMMARY

Why have an inquiry into health inequalities and the North?

The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments. Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country. The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health than a boy born in Richmond in London. Similarly, a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and prosperous socio-economic groups in the North than in the rest of the country. It is against this background that this Inquiry was set up.

Aims of the inquiry

In February 2014, Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Review Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North' - a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This programme was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry is to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place-based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bambra, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period February to July 2014. The policy sessions involved the submission of written discussion papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants). During the three further deliberative sessions held by the Inquiry the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

This report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

Policy drivers of inequalities and solutions

1. Economic development and living conditions

The difference in health between the North and the rest of England is largely explained by socioeconomic differences, including the uneven economic development and poverty. One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher unsecured debts in the North, all of which have an adverse impact on health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health. Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England. The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community. Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course.

The burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South;

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent

people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental and physical health problems. Poor psychosocial conditions at work increase risk of health problems, in particular cardiovascular conditions and mental health problems. More precarious forms of employment, including temporary contracts, are also increasing and these have been associated with increased health risks.

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.

This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties. In terms of physical health, debt has been linked to a poorer self-rated physical health, long term illness or disability, chronic fatigue, back pain, higher levels of obesity and worse health and health related quality of life.

What could be done differently?

The evidence reviewed by the panel has outlined a number of actions that have the potential to address the economic and employment causes of health inequalities. This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future, not least by investing in people (improving skills and health and hence employment prospects), as well as investing in places. This strategy links public service reform to economic development in the North, to refocus services on preventing poverty and promoting prosperity.

2. Early childhood as a critical period

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe. Within England, the health of children is generally worse in the North, reflecting the higher levels of child poverty.

There is a large body of evidence demonstrating that early disadvantage tracks forward, to influence health and development trajectories in later life, and that children who start behind tend to stay behind. For example, children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have repeatedly shown that providing better support early in children's lives is the most effective approach to significantly reduce inequalities in life chances. In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities. In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty. To address these targets, a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this period. Unfortunately, we are now seeing signs that these achievements are being undone. For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the health and well-being of children has the potential to engender a new commitment to investment in the early years.

The evidence indicates that two strands of action are required to significantly reduce child health inequalities at a population level. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises. Those countries in Europe that do have more adequate social protection experience better child health outcomes. The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Secondly, a system of high quality universal early years child care and education support is also necessary. In Nordic countries, a child's life chances are not so dependent on how privileged their

parents were than they are in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across society would effectively reduce inequalities. Providing any education is not enough, though, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects. This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities. The evidence base for these early interventions is strong.

3. Devolution: having the power to make a difference at the right spatial scale

The evidence suggests that there are three ways through which levels of community control and democratic engagement have an impact on health. Firstly, those who have less influence are less able to affect the use of public resources to improve their health and well-being. The Northern regions, for example, have had limited collective influence over how resources and assets are used in the North of England and this has hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.

Northern regions have had limited collective influence over how resources and assets are used and this has hindered action on health inequalities.

There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health. A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities. Countries with long-term social-democratic governments tend to have more developed preventive health services. US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability. There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social isolation and nurture a sense of community, trust and community competence. Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment. Evidence from the 65 most deprived local authorities in England shows that, as the proportion of the population reporting that they can influence decisions in their local area increases, the average level of premature mortality and prevalence of mental illness in the area declines.

A constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe, both political and economic power are concentrated in London and the surrounding area and this has contributed to the large inequalities between regions. The disproportionate cuts to local government budgets currently being implemented are exacerbating the problem. Successful regions will have control over the prerequisites of growth, such as skills, transport and planning.

What could be done differently?

Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England. Simply devolving power to city regions and combined authorities, however, will not, on its own, address inequalities. Giving local areas greater control over investment for economic development will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. Devolution of power and resources to local administrations needs to be accompanied by greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable to people living in the North, but decisions made by combined authorities or local economic partnerships will seem no more democratic unless there is greater transparency and participation.

There is the potential for devolution within England to herald a new approach to health inequalities

There is the potential for devolution within England to herald a new approach to health inequalities that is based on fundamentally shifting power from central government to regions, local authorities and communities. But only if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities – allowing them to do the right things at the right spatial scale.

None of this, however, should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

4. The vital role of the health sector

We did not consider that the observed health inequalities between the North and the rest of England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, these could not account for the size

and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this, NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need must be maintained.

The NHS can influence health inequalities through 3 main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care, free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces heath inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England. There is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes. This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it should not be at the expense of investment earlier in the life course, which is a vital component of all health inequalities strategies.

Access to NHS care when ill has helped to reduce health inequalities, amelioratating the health damage caused by wider determinants outside the health sector.

Thirdly a more community-orientated model of primary care needs to be encouraged that fully integrates support across the determinants of health. This includes enabling people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.

Fourthly a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.

Finally the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Recommendations

Tackling these root causes leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations are explained in detail in Section 4. These recommendations are formulated from a Northern perspective and address the core question: what can the North do to tackle the health equity issues revealed in this report? This perspective does not mean that we discount national actions – far from it – we give two types of recommendations for each high-level recommendation:

1) What can agencies in the North, do to help reduce the health inequalities within the North and between the North and the rest of England?

2) What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

We believe that the recommended actions would benefit the whole country, not just the North.

Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England.

Agencies in the North should work together to:

- Draw up health equity strategies that include measures to ameliorate and prevent poverty among the residents in each agency's patch;
- Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by re-orientating services to boost the prospects of people and place. This includes establishing integrated support across

the public sector to improve the employment prospects of those out of work or entering the labour market.

- Adopt a common progressive procurement approach to promote health and to support people back into work;
- Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery;
- Implement and regulate the Living Wage at the local authority level;
- Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.
- Assess the impact in the North of changes in national economic and welfare policies;

Central government needs to:

- Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people into work;
- Extend the national measurement of the well-being programme to better monitor progress and influence policy on inequalities;
- Develop a national industrial strategy that reduces inequalities between the regions;
- Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular;
- Expand the role of Credit Unions and take measures to end the poverty premium;
- Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market;
- End in-work poverty by implementing and regulating a Living Wage;
- Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL);
- Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets;
- Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.

Recommendation 2: Promote healthy development in early childhood.

Agencies in the North should work together to:

- Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need;
- Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs, so that all children achieve an acceptable level of school readiness;
- Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach;
- Collect better data on children in the early years across organisations so that we can track changes over time;
- Develop and sign up to a charter to protect the rights of children to the best possible health.

Central government needs to:

- Embed a rights based approach to children's health across government;
- Reduce child poverty through the measures advocated by the Child Poverty Commission which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;
- Reverse recent falls in the living standards of less advantaged families;
- Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated;
- Invest in raising the qualifications of staff working in early years childcare and education;
- Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused according to need;
- Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.
- Make provision for universal, good quality early years education and childcare proportionately according to need across the country.

Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.

Agencies in the North should work together to:

- Establish deep collaboration between combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities;
- Take the opportunity offered by greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people into employment;
- Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.
- Develop community led systems for health equity monitoring and accountability;
- Expand the involvement of citizens in shaping how local budgets are used;
- Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development;
- Help develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at local and national levels;

Central government needs to:

- Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve;

- Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities;
- Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities;
- Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.

Recommendation 4: Strengthen the role of the health sector in promoting health equity.

Public Health England should:

- Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services;
- Support local authorities to produce a Health Inequalities Risk Mitigation Strategy;
- Help to establish a cross-departmental system of health impact assessment;
- Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise Partnerships and combined authorities;
- Contribute to a review of current systems for the central allocation of public resources to local areas;
- Support the development a network of Health and Well-being Boards across the North of England with a special focus on health equity;
- Collaborate on the development of a charter to protect the rights of children;
- Work with Healthwatch and Health and Well-being Boards across the North of England to develop community-led systems for health equity monitoring and accountability.

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

- Lead the way in using the Social Value Act to ensure that procurement and commissioning maximises opportunities for high quality local employment, high quality care, and reductions in economic and health inequalities;
- Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained;
- Work with local authorities, the Department for Work and Pensions (DWP) and other agencies to develop 'Health First' type employment support programmes for people with chronic health conditions;
- Work more effectively with local authority Directors of Public Health and PHE to address the risk conditions (social and economic determinants of health) that drive health and social care system demand;
- Support Health and Well-being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities;
- Provide leadership to support health services and clinical teams to reduce children's exposure to poverty and its consequences;
- Encourage the provision of services in primary care to reduce poverty among people with chronic illness, including, for example, debt and housing advice and support to access to disability-related benefits.