Annual Report of the
Director of Public Health
2016-2017

The Impact of Austerity on Health and Wellbeing
FOREWORD

I am very pleased to write a foreword for this annual report which is a timely review of the health impacts of austerity and welfare reform measures have had on our residents.

Earlier this year Liverpool City Council’s Revenue and Benefits Department produced a cumulative impact analysis of the combined impacts of welfare reform that identified over 20 major changes to working age benefits affecting around 55,000 households in Liverpool. This annual report takes the opportunity to build on that analysis to identify and explore the health and wellbeing impacts of these reforms on the Liverpool population.

Some of the findings uncovered in the analysis include a significant rise in the number of hospital admissions for malnutrition for women of childbearing age as well as for children and young people, a 40% increase in admissions for self-harm, rising prevalence of depression and both common and severe mental illness, a 75% increase in the city’s suicide rate since 2008, and signs that life expectancy is beginning to fall (which has also been reported nationally). The report also highlights that it is residents living in our most deprived communities who have been disproportionately experiencing the associated health impacts of austerity, which will only serve to exacerbate health inequalities within the city.

Despite these challenges, the resilience of Liverpool’s residents and their communities to the impact of austerity has been evident through joint working between communities, local groups and services across the public, third and independent sectors. These partnerships have been key to maximising support for the most vulnerable and disadvantaged by finding ways to ensure people continue to have access to key services as well as assistance to maximise incomes and opportunities for sustainable employment.

The health of the Liverpool population remains a major asset for the city in achieving its goals for economic growth and development. Health therefore is both a pre-cursor and an outcome of wealth. Economic growth and the success of the city is dependent upon the health of the population both in terms of providing an environment for children to have the best start in life, boosting employability and productivity of adults and enabling older people to sustain their good health for longer into older years.

Our goal always has been to yield the highest attainable health benefits to vulnerable individuals and communities and the city as a whole. It is only by working together that we will be able to overcome the impacts of austerity and achieve those much needed improvements to health outcomes for people in Liverpool.

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Director of Public Health
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Introduction

What is austerity?

“Difficult economic conditions created by government measures to reduce public expenditure.” (Oxford English Dictionary)

In 2008, the UK entered a financial crisis following a global economic downturn. The situation worsened by 2010 and ultimately resulted in a programme of austerity measures and welfare reforms. This manifested as large-scale reductions in to central and local public sector budgets, as well as an NHS funding freeze, and cuts to welfare services and benefits in order to reduce public sector borrowing.

This Public Health Annual Report explores some of the possible health impacts that austerity and welfare reform measures have had on our residents, although it is likely that many of the consequences for health may not be apparent for many years to come. Economic changes occur rapidly, leading to deterioration in the social determinants of health, but consequent changes in health outcomes can have long latency periods and may take decades to become fully apparent.

Public Sector Spending

The cuts borne from austerity have hit councils hardest in some of the poorest parts of the country. Local authorities in England lost 27% of their spending power between 2010/11 and 2015/16 in real terms. For Liverpool, government funding has fallen from £523.7M in 2010 to £243.9M in 2017, and will fall further to £15M by 2019/20.

Particularly striking is the situation for social care spending (combining children and adult services). The Joseph Rowntree Foundation reported in 2015 that nationally funding has actually risen in real terms in the least deprived categories (by £28 per head) while falling strongly in the more deprived categories (by £65 per head). They argued that even relatively modest cuts to frontline services can have a substantial impact on the lives of poorer households who are more reliant on a range of public services so feel the cumulative impacts of multiple cuts.

Dahlgren and Whitehead (1992) described the layers of influence on health (see figure 1) and attempted to map the relationship between the individual, their environment and disease. Individuals are surrounded by these layers of influence on their health including lifestyle behaviours, such as smoking for example. Social and community networks set the basis for cultural norms, expectations and ways of community living but can also provide mutual support for members during difficult times. The outer layers include structural factors such as housing, working conditions, access to services and provision of essential facilities. These determinants of health are mostly modifiable and it is the experience of various facets of this model, such as becoming unemployed, being on a low income or having reduced access to services that can lead to poor health and health inequalities.
Figure 1: Dahlgren and Whitehead determinants of health model

Map 1 illustrates health inequalities in Liverpool compared with England overall. According to the 2015 Index of Deprivation, almost two-thirds (63%) of our communities are in the most deprived 10% of areas in the country. None of the city’s Lower Super Output Areas (a geographical area comprising approximately 1,500 residents) are categorised as being in the least deprived national deciles. Within Liverpool itself there are stark inequalities in health and these may have been, or continue to be, exacerbated by the programme of austerity.
Index of Deprivation 2015 - Health Deprivation Score Compared with England (Decile 1 = Most Deprived 10% in the country)

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Map 1: Health deprivation by national decile
Welfare and Benefits Reforms

The Due North report of the inquiry on health equity in the north of England found that on top of the cuts to local authority budgets, more deprived areas were experiencing large financial losses due to welfare reform. In 2012 the government announced £18 billion of welfare savings. This has had an impact not just on the individuals and families facing reduced incomes from welfare benefits, but has also represented a large loss to the local economy. Work by Sheffield Hallam University suggests that Liverpool had the fifth highest financial loss in the country by 2016 estimated to be £157M loss per annum, and 20th highest loss per working age adult estimated to be £480 loss per annum. However, by 2020/21 the loss to Liverpool is calculated to have increased to £292M per annum and to £900 per working age adult per annum.

Changes to the benefits system are still taking place, so the full impact on the health and wellbeing of people affected will not be known for many years. For example, from April 2017 there were changes to child tax credits meaning that people with two or more children would not be eligible for support if they had subsequent children, and Universal Credit would be limited for some new births.

Liverpool City Council’s Revenue and Benefits Department produced a Cumulative Impact Assessment on the impact of central government’s welfare changes. This identified over 20 major changes to working age benefits since 2010 that the Government has implemented or plans to implement, affecting 55,000 households in Liverpool. Some of the welfare reforms include the withdrawal of the spare room subsidy (bedroom tax) and the introduction of universal credit and a welfare cap. Map 2 shows that residents living in our more deprived communities to the north of the city have been particularly affected by the bedroom tax, with 1 in 9 households in Norris Green affected. One survey from the National Housing Federation found in 2014 that two-thirds of households affected by the bedroom tax had fallen into rent arrears, while 1 in 7 families had received eviction letters. Obviously such stresses are likely to have an impact of the mental health and wellbeing of individuals and this will be explored later in the report.
Reforms to the welfare system may exacerbate health inequalities. Welfare changes are likely to impact low-income households and vulnerable groups including:

- Workless households and households in more than 16 hours per week of low paid work
- Households with children
- Lone parents
- Larger families
- Disabled people who are reassessed and considered ineligible for personal independent payments.

As well as welfare reform, a range of benefits sanctions has been introduced. The Department for Work and Pensions have stated that if recipients do not attend meetings at job centres, apply for jobs or take jobs, they can have their JSA payments suspended. Employment and Support Allowance payments could be reduced until recipients meet compliance conditions.
A Liverpool Mental Health Consortium survey found that half of respondents had received a reduction in income due to welfare reform. A further 12% had suffered months of hardship (without any income) whilst waiting for a decision.

**NHS Expenditure**

Since 2010, for the first time in its history, the amount of money available to the NHS per head of population has declined. Whilst there has been continued investment in the NHS there has also been rising inflation and a rising demand, largely due to an ageing population, which has put the NHS under huge strain. This is reflected in Accident and Emergency four hour waiting times which are now consistently well below target (latest position for July 2017/18 was 89% compared with the 95% target), and the percentage of patients waiting 6 or more weeks for a diagnostic test stands at 10.3% compared with a target of 1%. Changes to the way NHS resources are allocated, including the abolition of the previous “health inequalities” policy, mean that cuts in funding have hit the poorest areas hardest.

The primary care system is also experiencing an unprecedented increase in workload. GPs are most people’s first point of contact with the NHS, and around 90% of patient interaction is with primary care services. Primary care has been seen as the solution to the NHS funding gap, with improved community care preventing people requiring expensive hospital care and yet GPs are frequently at the forefront of responding to patient’s health problems that occur as a result of material deprivation and disadvantage. The British Medical Association (BMA) has reported an increase in GPs workloads as a direct result of the Government’s reforms to the welfare system, and there hasn’t been the necessary investment in primary care to cope with the increasing demand.

**General Impacts**

The British Medical Association has reported a range of specific adverse impacts of austerity and welfare reform policies including:

- Reduced household income and a consequent inability to keep households warm, increasing the risk of mortality and a range of illnesses

  *In 2014/15, Excess Winter Deaths in Liverpool were at the highest rate since the turn of the millennium.*

- Increased mortality among pensioners aged 85+ years
There are signs that the standardised mortality rate is increasing in this population cohort in Liverpool. There has been a 5% increase in the mortality rate for 85+ year olds over the last 3 years.

- Deterioration or relapse of existing health conditions

There has been an increase in hospital admissions for respiratory conditions, an indication of living in a cold home.

- Rising levels of food insecurity and poorer diets in low income households

Liverpool adults consume 2.1 portions of fruit per day compared with 2.5 portions nationally, and consumption is falling.

- Increased prevalence of mental health conditions

Some 6,748 patients are on a GP register for a severe mental illness (1.32% of all patients) which is 16% higher than was the case in 2009/10 (1.1% of all patients)

- Increased suicide rates

There has been a 30% increase in Liverpool’s suicide rate since 2008-10.

- Increased rates of homelessness

The number of households contacting Liverpool’s Housing Options Service has risen in recent years and there was a significant increase in 2015/16.

It is difficult to definitively state the impact of the austerity and welfare reforms on the health of Liverpool residents, without conducting extensive local research with a representative sample of Liverpool residents. This report therefore summarises some of the national studies that have been conducted recently and explores if there have been likely health impacts on our population in the following topic areas:

- Child poverty
- Fuel poverty
- Food poverty
- Mental health
- Suicide
- Homelessness
- Mortality and Life Expectancy

Figure 2: General impacts of austerity and welfare reform
General Impacts of Austerity & Welfare Reform in Liverpool

Reduced Household Income
In 2014/15, excess Winter Deaths were at the highest rate since the turn of the millennium.

Increased mortality among pensioners aged 85+ years
There has been a 5% increase in mortality rate in those aged 85+ years over the last 5 years.

Rising Levels of Food Insecurity in low income families
Liverpool adults consume 2.1 portions of fruit per day compared to 2.5 nationally.

What is Austerity?
“Difficult economic conditions created by government measures to reduce public expenditure.” (Oxford English Dictionary)

In 2008, the UK entered a financial crisis following a global economic downturn, the situation worsened by 2010 and ultimately resulted in the Government implementing a programme of austerity, this manifested as large-scale cuts to central and local government budgets, as well as an NHS funding freeze, and cuts to the welfare services and benefits.

Increased prevalence in Mental Health conditions:
Some 6,748 patients are on a GP register for a severe mental illness (1.32% of all patients) which is 16% higher than was the case in 2009/10 (1.1% of all patients).

There has been an increase in Liverpool’s Suicide rate since 2008-10

Increased Suicide

Homelessness
The number of households contacting Liverpool’s Housing Options Service has risen in recent years and there was a significant increase in 2015/16.
Austerity and the Life Course

In June 2008 at a Ministerial Conference in Tallinn, Estonia, the WHO (World Health Organization) member states for Europe, signed up to what is known as The Tallinn Charter: Health Systems for Health and Wealth\(^\text{10}\). The UK was a signatory to this Charter.

The Tallinn Charter demonstrated the deeply rooted connections between good health as a precursor to economic growth and wealth (i.e. if we are healthy, we are more likely to be in work, happy and be more productive and less likely to retire early, suffer premature illness or death). Likewise, that wealthy individuals and populations experience better working and living conditions with resultant better health. The argument being that investing in sustainable health systems is essential, not only for improving health \textit{per se} but contributing and leading to economic growth and improved social wellbeing, with further health improvements and so on.

At the same time across the world in 2008, as mentioned earlier, an economic downturn was beginning that resulted in a global economic crisis, the collapse of several financial institutions, major pressures on public sector finances, unstable labour markets and in some countries significant rises in unemployment.

Goals of the Tallinn charter

In contrast to the programme of public sector reductions in 2008, the UK (and other WHO member states) had committed themselves to:

- **promoting shared values of solidarity, equity and participation** through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups;

- **investing in health systems and foster investment across sectors that influence health**, using evidence on the links between socioeconomic development and health;

- **promoting transparency and be accountable** for health system performance to achieve measurable results;

- **making health systems more responsive** to people’s needs, preferences and expectations, while recognising their rights and responsibilities with regard to their own health;

- **engaging stakeholders** in policy development and implementation;

* \textit{a ‘health system’ can refer to the set of connections between people, services, organisations and institutions in Liverpool that work together using its available resources, to support people’s health and wellbeing. This doesn’t just mean hospitals, GP surgeries and council services – but also community and voluntary groups, carers, families, as well as individual service users.}
• fostering cross-country learning and cooperation on the design and implementation of health system reforms at national and subnational levels; and

• ensuring that health systems are prepared and able to respond to crises, and that we collaborate with each other and enforce the International Health Regulations.

It is these commitments that were considered essential in realising the goals of improvements in health and health equity for countries with sustainable health systems, the argument being that without the necessary investment in health, in the context of austerity and economic decline, that economic growth would falter, health outcomes would worsen and health inequities would widen.

Whilst UK Government policy was to ‘ring fence’ NHS funding, in real terms that investment in healthcare spending slowed during the recession, resulting in the UK becoming a relatively low spender on healthcare compared with international neighbours. However, that ring fencing placed even greater pressure on local authorities in England which are particularly relevant for health outcomes due to the range of services provided by local councils that impact on health and wellbeing. There is now a growing body of opinion and evidence that appear to bear this out, suggesting a link between the adoption of austerity policies resulting in adverse health outcomes.

Whether or not these are accurate conclusions to draw, or indeed whether the economic crash had occurred or otherwise, achieving the goals associated with the Tallinn Charter reflect key features of what is required for sustainable health systems in the 21st century that are sufficiently resourced to cope with national and international crises. This would require a greater focus on partnerships across the whole health system, greater levels of integration across services underpinned by stakeholder involvement and a recognition that all sectors in the health system have a part to play in disease prevention and health promotion. Partners across Liverpool have recognised these challenges and have, throughout the period of austerity, been working in a way that supports the goals associated with the Tallinn Charter. This has been through building and strengthening integration of the system, for example through the partnership working between the Clinical Commissioning Group, the Local Authority and the work of the Health and Wellbeing Board through the Joint Health and Wellbeing Strategy and also other mechanisms such as the joint work through the Better Care Fund. Furthermore, there are a wide range of other strategic partnerships outside of ‘health’ that also have an impact upon health outcomes and through their roles, aim to enhance growth and development of the city.
and for it to become more resilient to the challenges that it may face.

That said, major challenges remain to improving health in Liverpool. In many aspects good progress is being made. Figure 3 highlights some of the key public health outcomes for Liverpool across the life course. Improvements are being made in some areas such as in premature cardiovascular disease and cancer mortality for example, although this contrasts with some other areas such as childhood obesity.

Poverty, a low wage economy, public sector and welfare reforms and their impact on accessibility to care and support are all key determinants of health. This is particularly relevant for children, young people and their parents who have faced some of the disproportionate impacts of the recession and a decline in children’s wellbeing since 2008. There is also good evidence that the cumulative effect of the welfare reforms are likely to increase levels of child poverty with almost one million more children pushed into poverty by 2022. Vulnerable families including those with disabled children; lone parents; families at risk of homelessness; families with three or more children; and other vulnerable groups will be most affected.

The stresses and difficulties for families and communities and the resultant impact upon health and wellbeing cannot be underestimated. People cope in many different ways with the levels of stress and pressures of modern living which for some can lead to the adoption of lifestyles that unconsciously help regulate stress and providing some relief from exposure to low incomes, disadvantage and inequality, for example through smoking or excessive alcohol intake. We see evidence of this in the life course statistics in Figure 3 which show that exposure to risk factors to poor health including material deprivation, poverty and disadvantage can impact across the lifecourse from before birth, through childhood and adolescence with health impacts into adulthood and older years.

Liverpool has come a long way since 2008 and its own success as the European Capital of Culture. That success provided a springboard to significant investment in the city, into which growth and economic progress have sustained through the period of austerity. Despite these successes, reductions in public service spending has been taking its toll on the population but Liverpool has taken important steps through city and city region partnerships to respond to the challenges of austerity and welfare reform. It is these steps that are key to building and maintaining a sustainable health system as set out in the Tallinn Charter. It is the commitments outlined in that Charter that are just as relevant at city level as nationally and internationally, with a focus on the involvement of stakeholders to promote democratic accountability and transparency as well as playing a role in redesigning services to make them more responsive to need in the population. The steps being taken by partners in the city have meant that services are more prevention orientated and becoming increasingly integrated and joined up in their delivery.

*Figure 3: Liverpool’s life course statistics compared with England (Source: Liverpool Public Health Epidemiology Team)*
Liverpool's life course statistics
A comparison to England

LIVERPOOL FACTS

Population
About 478,580 people live in Liverpool.
By 2035, this is projected to increase to 493,889 people.
Around 11% of people class themselves as part of a minority ethnic group.

Deprivation
45% of Liverpool's population live in the top 10% most deprived areas in England.

Child Poverty
1 in 3 children live in poverty.

KEY
Direction of travel
△ Improved since last period
▲ Similar to last period
▼ Worse than last period
〇 No trend data available

Statistical significance to England
Better
〇 No different
Worse

For more information & data sources please contact Liverpool City Council’s Public Health Epidemiology Team:

Data Sources

1 Public Health Outcomes Framework (PHO)
3 Child Health Profiles (2012)
4 ONS
5 Census 2011
6 Dementia Profile (PHO)
The Impact on People

Although austerity measures have likely impacted in some way on all Liverpool residents, as mentioned earlier there are particular groups of people that have been identified as being hit hardest. Liverpool City Council’s Welfare Reform Cumulative Analysis report highlighted certain groups of people who had been particularly impacted upon by the changes to the benefits system. The findings from this interim report have helped to galvanise the Council and its partners to develop an approach to supporting those affected by the current and future welfare reforms.

Women

Engender, an organisation focusing on gender equality issues and based in Scotland, found that women are more financially dependent on social security than men, with 20% of women’s income coming from the benefits and tax credit system. Women comprise 92% of lone parents and 95% of lone parents dependent on Income Support. They have contributed £5.8 billion of the £8 billion raised in changes to taxes and benefits by the UK Government since 2010. They conclude that changes to tax credits, child benefits and public sector pensions implemented across the UK have hit women particularly hard.

There is evidence that levels of domestic abuse rise in times of economic crisis and women are disproportionately affected by this. The difficulty of leaving a violent partner is complicated by financial limitations. The Fawcett Society, a UK charity that campaigns for gender equality and women’s rights, has reported that women are:

1. **Hardest hit by cuts to public sector jobs, wages and pensions.**
   Women account for 64% of the public sector workforce overall. This sector has experienced job cuts, a pay freeze, and pension reform all of which have hit women disproportionally.

2. **Hardest hit by cuts to services and benefits**
   Women have greater caring responsibilities, including for children, older people, and sick or disabled people, and women use public services, which have been placed under strain, more intensively than men.

3. **Most likely to “fill the gaps” left by the withdrawal of state services.**
The 2011 Census found that almost 30,000 women in the city provided unpaid care, with 3 out of 10 of these providing more than 50 hours unpaid care a week.

People out of Work

The adverse impact of unemployment on health is well established. Unemployment is associated with an increased likelihood of morbidity and mortality, and this likelihood of becoming ill when unemployed in turn drastically reduces the chance of gaining employment. The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community\(^2\). Liverpool’s male unemployment rate was as high as 15% in 2010, before falling to 9% in 2016/17, although it is 1.8 times higher than the England rate. In 2016, there were almost 40,000 “workless” households (defined as those where no occupant is in employment) in the city which represented 24% of all households (England=15%).

Youth unemployment has long term consequences for mental and physical health across the life course. Furthermore the proportion of Liverpool 16-18 year olds Not in Education, Employment, or Training is statistically significantly higher than the national average (6.3% compared with 4.2%).

Although unemployment has reduced both locally and nationally since 2010, there has been a rise in the number of people on temporary and “zero hour” contracts, and these are associated with increased health risks\(^2\). These contracts can result in people taking out payday loans and/or accumulating debt, and people in debt are 3 times more likely to have a mental health problem than those not in debt\(^2\). According to the Office for National Statistics in 2010, 168,000 people in the UK were in employment on a zero hours contract and by 2016 this number had risen to 905,000.

Reduced opportunities for employment increases income poverty, restricts food budgets, decreases housing security/quality, and harms parental mental health\(^20\).

People with Disabilities

Overall people with disabilities are set to lose £28bn of support from 2010 to 2018, with this figure being exacerbated by pressures on local authority budgets\(^21\). As well as cuts to services, welfare reform has resulted in people who have disabilities and claim benefits because they are unable to work being subjected to stringent medical assessments\(^22\). Concerns have been raised about the
effectiveness and fairness of these assessments, in addition to the potential for adverse mental health consequences. Similar changes are being applied to benefits that contribute towards the additional care and mobility related costs faced by people with disabilities\textsuperscript{23}, and changes to housing benefit and council tax also disproportionately affect people with disabilities. Mencap has warned that people with learning disabilities are struggling with assessment processes for new welfare systems\textsuperscript{24}. Some 0.5\% of Liverpool adult patients are registered with their GP as having a learning disability, which means that potentially up to 2,150 people in the city may be struggling with the reforms.
Child Poverty

Recent analyses of austerity policies in the UK suggest that children are amongst the groups being hit hardest. A number of the changes to the welfare and benefits system have been detrimental to children, including the abolition of the education maintenance allowance, health in pregnancy grants and child trust funds, the freezing of child benefit, the removal of working tax credit from couples working 16-24 hours, changes to child tax credits meaning that people with two or more children would not be eligible for support if they had subsequent children, and Universal Credit being limited for some new births. Spending on children’s centres has fallen by 28% nationally.

Levels of child poverty have been increasing in Liverpool over recent years. Latest estimates produced by The Centre for Research in Social Policy suggest that more than 1 in 3 of our children are living in poverty. In two electoral wards (Princes Park and Picton), more than half of our children are estimated to be living in poverty whilst in Church ward this is likely to be the case for 1 in 11 children.

Map 3: Children Living in Poverty

Children living in poverty and experiencing disadvantage are more likely to:

- Die in the first year of life

The number of deaths of Liverpool infants, particularly new born babies, fluctuates on an annual basis. However, in 2016 provisional data shows that there were 39 infant deaths in the city which is the highest recorded number since 2005.
• Be born small

Some 8.5% of births in Liverpool are of a low birthweight (England=7.4%) compared with 7.4% in 2010.

• Breathe second hand smoke

Some 14% of Liverpool mothers are smokers at the time of delivery of their baby. Smoking prevalence at the time of delivery is five times higher in the most deprived wards in the city compared with the least deprived wards. The range across Liverpool is from 1% of new mothers in Church ward to 29% in Anfield.

• Become overweight

In 2015/16, 12% of Reception age children and 24% of Year 6 children in Liverpool were classified as obese (England rates were 9% and 20% respectively). In Kirkdale, one of Liverpool’s most deprived wards, some 40% Year 6 children were classified as being obese compared with 14% in Mossley Hill, one of our least deprived wards.

• Perform poorly at school

In 2016, just over half of Liverpool children attained 5 A-C grades including English and Maths which was significantly lower than the England average of 58%. In some of Liverpool’s most deprived wards only a third of pupils attained this level of achievement compared with three-quarters of pupils in the least deprived wards.

• Die in an accident

The number of Liverpool children killed or seriously injured in road accidents is more than twice the England rate.

• Become a young parent

Liverpool’s teenage conception rate of 32 per 1,000 women aged 15-44 years remains significantly higher than the national rate. County, Everton, Kirkdale, Picton, Riverside, and Speke-Garston have the highest teenage conception rates in the city which are significantly higher than the Liverpool rate.
Child Poverty in Liverpool

1 in 3 children in Liverpool is living in poverty.

Recent analyses of austerity policies in the UK suggest that children are amongst the groups being hit hardest.

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Become a young parent

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The combined effect of benefits changes and the national living wage will impact hard on lone parents and families with children who depend on welfare support. A lone parent working full time with one child was just short of the minimum income standard in 2010 but will have around 70% of the minimum income for a decent living by 2020\textsuperscript{25}. In contrast a couple without children and pensioners will be better off. The Resolution Foundation estimates that an extra 600,000 children will be in poverty once all the policy measures have taken effect\textsuperscript{26}.

In 2015/16, some 6 out of 10 Liverpool children were not reaching an acceptable level of development as they entered school, which increased from 5 out of 10 children in 2012/13. Michael Marmot showed that disadvantages early in life tracks forward to influence health and social outcomes in adulthood. If fewer children were exposed to poverty we would have a much higher percentage of children reaching a good level of development, leading to better health and development for all. Numerous epidemiological studies over the past 40 years tell us that children who start behind tend to stay behind.

There is now compelling evidence that early exposure to poverty directly affects the developing brain. Child poverty influences the development of specific areas of the brain that are critical for the development of language, executive functions, and memory\textsuperscript{27}. Data from the UK shows that exposure to adversity in the early years of life is associated with higher levels of childhood mental health problems, such as depression and anxiety, and altered brain structure in adolescence\textsuperscript{28}.

Exposure to poverty in early life has been shown to be associated with a higher risk of chronic health conditions of elderly people such as cardiovascular disease and Alzheimer’s disease\textsuperscript{1}.
What Liverpool is doing

Liverpool is globally recognised as a centre of cultural heritage and a vibrant modern setting, full of opportunity to engage in enriching community activity. Underpinning and supporting this wealth of local assets is a committed local health, community and voluntary sector working in partnership to identify and meet the needs of children and young people and to ensure that every child in Liverpool has the best possible start in life, in spite of the impact of austerity. The Liverpool Early Help Directory provides accessible information on the vast range of support available to children, young people and families in Liverpool. With everything from play schemes to more structured support, the Early Help Directory (http://ehd.liverpool.gov.uk/kb5/liverpool/fsd/results.page?familychannel=0) is testament to the local commitment to ensuring the best possible outcomes for children, young people and families in Liverpool.
Fuel Poverty

“People have to choose to heat or eat”

Poor housing along with high energy bills and low incomes, all contribute to fuel poverty. The poorest tenth of households spend more than a fifth of their budget on fuel, and living in fuel poverty can adversely affect mental and physical health of children and adults with the costs to the NHS estimated at £2.5 billion a year. According to the Department for Business, Energy and Industrial Strategy, a household is defined as being in fuel poverty if, in order to maintain a satisfactory heating regime and cover other normal fuel costs, it would be required to spend more than 10% of its income on all household fuel use. In 2015, some 14.3% of Liverpool households were fuel poor which was the 22nd highest rate of 326 local authorities, and equated to over 30,000 households in the city. Furthermore the rate has not changed over the last five years.

The map below illustrates those parts of the city particularly affected by fuel poverty. The range at the Lower Super Output Area geography is from 5% to 47%. Whilst some of the more deprived parts of the city, including County, Anfield, Kensington and Fairfield, Picton, and Norris Green, are particularly affected by fuel poverty, there is only moderate (r=0.3) statistical correlation between deprivation and fuel poverty at the Lower Super Output Area geography. There are therefore pockets of fuel poverty households across the city including in the less deprived areas where there may be larger houses occupied by lone pensioners to give an example.
Map 4: Fuel Poverty
There is an association between respiratory illness (bronchitis, pneumonia, influenza, emphysema, and other chronic obstructive pulmonary disease) and people living in cold homes. Respiratory disease is the third biggest killer in Liverpool and whilst the city’s premature mortality rate for cardiovascular disease and cancer have fallen since 2010, by 21% and 12% respectively, the rate for respiratory disease has actually increased by 12%. Furthermore the premature mortality rate from respiratory disease that is considered preventable has also increased from 34 deaths per 100,000 in 2010 to 40 deaths per 100,000 in 2015.

![Chart 1: Premature mortality rates (Source: Office for National Statistics, PHE)](image)

The Liverpool Public Health Epidemiology Team explored hospital admissions for a respiratory disease condition between 2012/13 (the earliest period for which admissions data is available) and 2016/17, and the data showed that Liverpool residents were 1.3 times more likely to be admitted to hospital in 2016/17, and their risk of being admitted had also increased by a third. Whilst the rate of respiratory admissions had increased across the city, there had been a widening of the gap between the most and least deprived parts of the city over the last five years. In 2016/17, Liverpool’s most deprived quintile (comprised of the 6 most deprived wards in the city) accounted for 23% of respiratory disease admissions whilst the least deprived quintile accounted for 14%.
What Liverpool is doing

The Healthy Homes programme commissioned by Public Health aims to lift the most vulnerable and those in need of help, out of poor and cold housing conditions. The programme provides physical energy improvements, behavioural advice and income maximisation for people living in fuel poverty or at risk of fuel poverty. As well as outreach in local communities, they also hold surgeries at Citizens Advice Bureaus, GP practices and community centres amongst a range of other activities. Each year the programme has a Winter Survival programme, following which they run 30 roadshows across the city. The service has a Freephone number 0800 012 1754.
Food poverty

Organisations providing food-aid are consistently reporting increases in demand. The Trussell Trust is a non-governmental organisation that coordinates food banks in the UK. In 2009/10 Trussell foodbanks were operating in 29 local authorities; this had risen to 251 by 2013/14. In that year Merseyside was described as the Foodbank capital of the country (as reported in the Liverpool Echo), with 35,175 adults and 20,936 children reliant on emergency parcels of food and basic household supplies. The primary reasons reported for the rise in use of food-aid are benefits sanctions, delays in welfare payments, crisis in household income due to low wages, rising food costs, and household debt.

The rapid spread of foodbanks has raised concerns from the UK’s Faculty of Public Health that “the welfare system is increasingly failing to provide a last line of defence against hunger”. GPs have also raised concerns about patients seeking referrals to foodbanks. A joint report from the Trussell Trust, the Church of England, and the charities Oxfam and Child Poverty Action Group found that foodbank users were more likely to live in rented accommodation, be single adults or lone parents, be unemployed, and have experienced a “sanction” where their unemployment benefits were cut for at least a month. An All Party Parliamentary Inquiry into Hunger and Food Poverty echoed concerns that economic hardship, austerity measures, and benefit sanctions could underlie the rise in emergency food aid.
To access a Trussell Trust foodbank people must obtain a referral voucher from a frontline care professional. Individuals take their voucher to a foodbank during opening hours and are provided with a parcel intended to contain enough food for the household to last 3 days. Between 2010 and 2013 the rate of food parcel distribution tripled. In 2016/17, the North West region had the highest number of 3 day emergency food supplies given by Trussell Trust foodbanks in the UK with almost 175,000 distributed.

Research conducted by Loopstra et al.\textsuperscript{33} gave the estimated likelihood of a food bank opening in an area that did not experience a spending cut in the 2 years under review was 14.5%. This figure tripled to 52.0% for a local authority that experienced an average budget cut of 3% in welfare spending in both years. Local authorities with greater rates of sanctions and austerity are experiencing greater rates of people seeking emergency food assistance.

Studies in the UK have demonstrated a significant adverse effect of the economic crisis on food intake by children, and specifically in vulnerable children\textsuperscript{1}. In 2012, 500,000 children in the UK lived in families who could not afford to feed them properly. The increasing price of food has also led to increasing consumption of carbohydrates and fast food. A Department for Environment Food and Rural Affairs (DEFRA) report stated that households purchased 4.2% less food in 2011 than in 2007 while spending 12% more. Low income decile households bought less fruit and veg. Food was often the first area to be cut in the family budget. Families buy food from cheaper supermarkets, buy less fresh fruit and veg and more frozen products\textsuperscript{33}. Another way to reduce costs for families on lower incomes is buying food that would fill children up ie foods high in fat or carbohydrates. Children living in families without resources or without social protection mechanisms due to austerity measures are at greater nutritional risk, including both obesity and undernutrition\textsuperscript{1}.

Fast food outlets are a particular concern with Liverpool having more of these per head of population than many other areas of the country, particularly in the more disadvantaged parts of the city. Out of 325 local authorities in England, Liverpool had the 34th highest density of fast food outlets with 116 per 100,000 residents (Source: Public Health England, 2014). High numbers of these outlets are associated with higher rates of obesity and the high concentration of processed food, saturated fats, refined sugars and salt all compound a picture of poor nutrition in vulnerable communities.
More than a quarter of Liverpool reception age children are either overweight or obese, and this rises to 4 out of 10 for Year 6 aged children. Both these figures are significantly higher than the national rates of 22% and 34% respectively. There is large variation within the city as well which mirrors levels of deprivation. For example, some 40% of Kirkdale (2\textsuperscript{nd} most deprived ward in the city) children in Year 6 are categorised as being obese compared with 14% in Mossley Hill (2\textsuperscript{nd} least deprived ward).

Focus Groups\textsuperscript{18} conducted in Liverpool found that all women who participated reported having less money and all were falling behind with their bills and having to choose between food and utilities. Women were depending on food vouchers and referrals to the clothes bank. They reported about lethargy brought on by a poor diet.

Not only have obesity rates amongst children increased due to poor diet, conversely it has been reported that malnutrition rates have also increased at a greater rate in the North of the country than in the South\textsuperscript{34}. Anecdotally, some 12% of women surveyed by the Liverpool Mental Health Consortium stated that they had “missed food” and a further 12% had used a food bank. One comment from the research was that “Women are foregoing food to feed their kids”\textsuperscript{18}.

The increased use of food banks correlates strongly with increased hospital admissions for malnutrition\textsuperscript{9}. This statement is supported by local data on hospital admissions for malnutrition or other nutritional deficiencies to women of childbearing age (defined as those aged 15-44 years). Between 2015/16 and 2016/17, women in this age-group were 3.7 times more likely to be admitted to hospital for malnutrition than was the case between 2012/13 and 2013/14. There was also a 4-fold increase in their risk of admission for this condition.

Likewise children and young people aged under 25 years were 2.8 times more likely to be admitted to hospital for malnutrition over the same time period. (Source: Liverpool Public Health Epidemiology Team)

What Liverpool is doing

**Positive About Play** engages with children and families during the school holidays. As well as providing free play activities for children, the Play Healthy aspect provides breakfast and lunch clubs and healthy eating activities. The play schemes have an important role in making sure that children are fed which is especially important for those children who are on free school meals during term time and whose parents may struggle to meet the costs of a packed lunch over the holiday period. Play Advice works with partners from the Citizens Advice Bureau, to provide a dedicated helpline and support for families attending the play schemes. In the
summer of 2016, over 2,700 children in the city attended a play scheme, and 80% of schemes ran cookery/nutrition sessions. Almost 50,000 meals and snacks were served.

**Food Insecurity.** The increasing rates of hospital admissions for malnutrition are a concern. There is no doubting the difficulties for families in managing their food budgets in difficult times, is compounded by the high concentration of fast food outlets. In Liverpool, as in other parts of the country many people and groups are already acting to support those in food poverty and tackle its root causes. The Mayoral Action Group on Fairness and Poverty have recognised the rising levels of food poverty in the city as a priority issue and under its auspices, a Food Insecurity Strategy Group has been formed to bring together partners across the city to coordinate action to address food insecurity. As it formulates its strategy one of its first steps is to understand more about the extent of food poverty in the city and to use that evidence to press for further action at a national level and support a local joined up response.
Mental Health

It is no surprise that austerity, combined with a rise in child poverty and foodbanks, has impacted on the mental health of our residents.

The Liverpool Mental Health Consortium conducted a questionnaire survey and focus groups with 70 Liverpool residents in 2017, and found that almost all (94%) of those surveyed stated that austerity and welfare reform had impacted on their mental wellbeing. Austerity had caused anxiety (49%), stress (43%), depression (24%), or had made existing conditions worse (14%). Some 8% had reported suicidal feelings due to the benefits process. Focus groups conducted with women found that austerity was having a big impact on their emotional health. Women were feeling morbid with regard their own futures and those of their children, and feeling anxious, stressed and depressed.

The Citizens Advice Bureau (CAB) has seen a shift in the issues generating distress in their service users, mainly increasing poverty and people reporting that they are suffering from tough back to work policies. There has also been an increase in people presenting with urgent issues related to having no money, no food, or no heating. Services have reported people who have been positively managing their mental health over the years suffering relapses.

Over 38,000 Liverpool patients are now on a GP register for depression which is 1 in 11 people in the city. This is 48% higher than the number on a register in 2012/13. It has been estimated that as many as 86,000 residents have a common mental health disorder such as depression or anxiety.

Intentional self-harm is an indicator of a person’s mental health and wellbeing. The risk of a Liverpool resident being admitted to hospital for an incident of intentional self-harm was 40% higher in 2015 to 2017 than was the case in 2012 to 2014. Emergency admissions due to intentional self-harm were most prevalent among our deprived communities and there has been a widening of the gap in admissions between the most and least deprived parts of the city over the past five years. The most deprived ward quintile in Liverpool accounted for 28.4% of intentional self-harm emergency admissions in 2015/6 – 16/17 while the least deprived quintile accounted for 8.7% (Source: Liverpool Public Health Epidemiology Team).
What Liverpool is doing

The City has re-launched its key stakeholder group: The Mental Health Making It Happen Group (MHMIHG). This group will pull together all aspects of mental health activity – well-being promotion, prevention of illness, treatment as well as rehabilitation to recovery. It will be the vehicle for implementing the latest PHE guidance on the Prevention Concordat for Better Mental Health. In addition the city has invested in:

- Workplace Wellbeing Charter – encouraging employers in the city to have policies in place to promote workforce wellbeing
- Community Health Ambassador Team – engaging people in group work to become less socially isolated.
- Health Trainers – increasing the life expectancy of those living in the most deprived neighbourhoods
- Emotional Health and Wellbeing school nurses to build capacity and skills in the workforce and strengthen family relationships
- Adopted a whole school approach to Mental Health and Emotional Wellbeing
- Delivered an advice on prescription service to maximise personal assets
- Trained workers in Youth Connect 5 - a programme to build resilience for parents and their children.
- Reviewing day opportunities to promote wellbeing, improve social inclusion and recovery rates.

The Cass Foundation led a £1.8m project to redirect the River Alt in Croxteth, creating a new park (Alt Meadows) and a programme of community engagement to develop the Friends of Croxteth Green Spaces. This has created new greenspace to be enjoyed by the local community and will have positive benefits for mental wellbeing.
Suicide

A systematic evidence review of the impact of the financial crisis dating from 2008 conducted by Parmar et al. found that there had been a significant increase in suicides particularly amongst men. In England, Barr et al. reported 846 more male suicides nationally and 156 more female suicides between 2008 and 2010 than would have been expected based on previous trends.

In 2008-10, Liverpool’s directly age-standardised mortality rate for suicide was 5.9 deaths per 100,000 population, and this had increased to 10.3 deaths per 100,000 in 2013-15; a 75% increase in the rate.

Suicide is a complex and multi-faceted behaviour, and there is usually no single reason why someone would take their own life. Published research has identified socioeconomic factors as being key for suicidal behaviour. Increases in suicide are linked to economic recessions, and the risk remains high when crisis end especially for individuals whose economic circumstances do not improve. The risk of suicidal behaviour is increased among those experiencing job insecurity and downsizing or those engaged in irregular and short-term contracts.

The following are also risk factors and for each of these Liverpool has a statistically significant poorer outcome than the national average:

- Recorded depression (9.2% of Liverpool adult patients compared with 8.3% of England patients)
- Recorded severe mental illness (1.3% of Liverpool adult patients, 0.9% in England)
- Opiate usage (16.5 per 1,000 compared with 8.4 per 1,000)
- Alcohol-related hospital admissions (969 per 100,000 compared with 647 per 100,000)
- Long-term mental health problems (7.6% compared with 5.7%)
- Self-reported wellbeing (7.4% of Liverpool adults have low wellbeing compared with 4.6%)
- Looked after children (114 looked after children per 10,000 children, compared with 60 per 10,000)
- Domestic abuse (28 incidents per 1,000 population, compared with 20 per 1,000)
- Unemployment (6.5% compared with 4.7%)
- Long-term unemployment (0.6% of people are in long-term unemployment, compared with 0.4%)

Since 2012 the odds of a Liverpool resident dying from suicide has increased by 40%. The most deprived ward quintile (Everton, Kirkdale, Kensington and Fairfield, County, Anfield and Princes Park wards) have had the greatest excess death rate from suicide in 2012-16 while the most affluent quintile (Church, Mossley Hill, Woolton, Childwall, Allerton and Hunts Cross and Cressington wards) have had the largest shortfall. The most deprived ward quintile in Liverpool accounted for 28.3% of deaths from suicide in 2012-16 while the least deprived quintile accounted for 12.2% (Source: Liverpool Public Health Epidemiology Team).
What Liverpool is doing

No More, Zero Suicide is the Public Health led Cheshire and Merseyside partnership joint suicide prevention strategy whose aim is to eliminate suicide and provide support to people at a time of personal crisis. The four strategic aims are:

- becoming a suicide safe community,
- the health care system transforms care to end suicide for patients,
- to provide accessible support for those exposed to suicide,
- and have a strong Suicide reduction network.

Suicide prevention skills and knowledge can save a life, change attitudes and encourage positive practice. A suicide training framework has been developed that directs the workforce to training resources and modules appropriate to them. Liverpool City Council is looking to implement online suicide training for all its workforce and to make this training mandatory.
Homelessness

The statutory homelessness system in England, first legislated in 1977, places a duty on local authorities to secure accommodation for those making claims for homelessness assistance who meet statutory homelessness criteria. They are also required to offer other assistance to those who do not meet priority need criteria but are experiencing homelessness. After nearly a decade of decline in the number of such people, there was a reversal in 2010 when rates began to rise. This is a concern for public health as homelessness increases risks of infectious disease, physical harm, food insecurity, multiple morbidities and premature mortality. People who are homeless are 35 times more likely to die from suicide than the general population.

Homelessness is frequently a consequence of extreme poverty amongst groups who are disabled, have histories of mental health problems and/or substance misuse, and whose housing arrangements are unstable.

Reduced income and cuts to social safety nets such as housing support budgets are two factors that could explain why homelessness has risen so sharply in England. Rising unemployment and falling income can lead to emotional distress leading to mental health problems, domestic violence and family breakdown. Some public health charities express concern that budgetary cuts to funding for homelessness prevention, housing benefits, and social services are a major factor, for these play critical buffering roles during times of hardship.

Loopstra et al. found that each 10% fall in economic activity at the local authority level was associated with an increase of 0.45 homelessness claims per 1,000 households. Increasing rates of homelessness were also strongly linked with reductions in welfare spending. The strongest associations with reduced homelessness claims were spending on social care, housing services, discretionary housing payments and income support for older persons. Recession and austerity measures are associated with significant increases in rates of homelessness assistance. Liverpool City Council has continued to prioritise and invest in ensuring people do not go homeless and has published a Homelessness Strategy for 2016-2020.

Liverpool’s Housing Options Service (HOS) sees people who are more likely to be threatened with the loss of their home. The number of households contacting the service is steadily increasing following a significant increase in 2015/16. There was a 5% increase in HOS contacts in 2016/17 from the previous year (5,330 compared with 5,054). In 2016/17, 537
households were assessed as statutorily homeless and the council accepted 64% of these as homeless.

**What Liverpool is doing**

Liverpool City Council has published a Homelessness Strategy for 2016-2020, whose aim is to prevent and reduce homelessness and rough sleeping over the next five years. The three priorities identified were:

1. **Adopt an early prevention and intervention approach directed particularly towards single people and childless couples**

2. **Develop and encourage economic resilience, including through access to affordable settled housing**

3. **Address the needs of people who are homeless and have complex needs**

The full strategy is available at [http://liverpool.gov.uk/media/1355671/homeless-strategy.pdf](http://liverpool.gov.uk/media/1355671/homeless-strategy.pdf)
Mortality

A recent paper[^39], which gained attention in the national press, highlighted 2015 as having one of the largest increases in deaths in the post-war period. The authors’ identified dementia as making the greatest contribution to this dramatic rise in mortality, and that the additional deaths were largely among the older population who are the most dependent on health and social care.

Possible reasons for this rise in mortality were explored in a separate paper[^40]. The authors rejected delays in the registration of deaths, cold weather during the winter months, and influenza strain A (H3N2) alongside the less effective vaccine in use in 2014-15 as being the causes of the increase. Instead they identified the failure of the health and social care system and the levels of spending on the NHS and other essential services as a potential cause requiring further exploration. In early 2015 markers of NHS performance deteriorated, calls to NHS 111 rose dramatically, ambulance call-out times fell below target, waiting times in A&E increased, waiting times for diagnostic tests and consultant-led care increased, the cancellation of operations rose markedly, and delayed transfers for care peaked. In combination with these factors, the impact of social care cuts and the national decline in care home beds has contributed to delayed discharges from hospital leaving elderly people vulnerable and at increasing risk of death, the authors argue.

Loopstra et al found that greater reductions in social care per capita were associated with a significant rise in old-age mortality. Budgetary reductions to incomes (in the form of Pension Credit) of the poorest pensioners may have increased their vulnerability and risk of mortality. For the poorest pensioners, a change of even a few pounds could make a considerable difference to disposable income. Declines in income can cause considerable stress and anxiety to people of older ages, which could precipitate heart attack or stroke. There could also be reduced nutrition, inadequate heating, damp, and social isolation.

Here we explore if the increase in mortality reported on nationally between 2014 and 2015 has also occurred in Liverpool. The following points should be noted:

- The number of deaths in Liverpool increased from 4,200 in 2014 to 4,452 in 2015 (an additional 252 deaths) representing a 6.0% rise. This was marginally higher than the 5.6% increase observed nationally.
• The increase in the number of deaths was more prominent amongst Liverpool’s older population aged 65+ years, where there was a 7% rise, compared with a 3% rise in the number of under 65 years deaths.

• The 80-84 years cohort accounted for more than half of the additional deaths recorded in 2015. Between 2014 and 2015 the number of deaths in this age-group increased by a fifth.

• The rise in the number of deaths resulted in Liverpool’s directly age standardised mortality rate to increase by 4.8% (England=4.2%).

• The rise in deaths impacted on both the female and male mortality rates, with the former increasing by 4.4% and the latter by 3.9%.

• The specific disease types which experienced the largest increase in deaths were circulatory disease (85 additional deaths), dementia (50), and pneumonia (43).

• This led to an 8% rise in the circulatory disease mortality rate, a 13% rise in the dementia rate, and a 29% rise in the pneumonia rate in just one year.

As in the rest of the country Liverpool’s life expectancy experienced decades of year-on-year growth, albeit with rates significantly below the national average. However, from 2011 life expectancy in the city showed signs of plateauing. The increase in mortality in 2015 resulted in a significantly large reduction in male life expectancy of 0.5 years from 76.8 to 76.3 years. For Liverpool females, life expectancy fell from 80.7 to 80.4 years. This reduction was repeated across all age-groups. Worryingly, provisional data suggests that these decreases will continue through 2016 with male life expectancy falling to 76.2 years and female life expectancy to 80.0 years.

*Chart 2: Life expectancy Trend (Source: Office for National Statistics)*

![Trend in Liverpool's Life Expectancy at Birth](image)
Healthy life expectancy at birth is a measure of the average number of years a person would expect to live in good health, and this indicator is also showing signs of decreasing for Liverpool residents. Our male residents can expect to live in good health until they are 57.4 years old which compares unfavourably with 59 years reported in 2010, and is significantly lower than the national average of 63.4 years. Likewise, our female residents can expect to live in good health until they are 57.7 years (England=64.1 years) and this figure has also been declining.

However, there have been areas of significant improvement with regards mortality considered to be preventable. This is defined as deaths that could be potentially avoided by public health interventions in the broadest sense, such as deaths from drug and alcohol abuse for example. Since the start of the financial crash in 2008, Liverpool has experienced a 17% reduction in its preventable mortality rate which was higher than the 13% seen nationally and was the highest reduction of the English Core Cities.

Chart 3: Change in preventable mortality (Source: Public Health England)

What Liverpool is doing

Liverpool Joint Strategic Needs Assessment (JSNA) is an ongoing process that identifies the key issues affecting the health and wellbeing of our residents, both now and in the future. The JSNA provides a basis for the development of the Joint Health and Wellbeing Strategy which is a reference point for all those working to improve health and reduce inequalities. The JSNA has led to stronger partnership working across organisations and, with an emphasis on prevention, contributed to the above fall in preventable premature mortality. All of the city’s JSNA information can be found at www.liverpool.gov.uk/jsna
Conclusion and Recommendations

The body of evidence provided in this year’s Public health Annual Report highlights the impact of austerity and welfare reform on the health and wellbeing of the population. It builds on the Cumulative Impact Analysis of Welfare Reforms Report⁵, produced earlier this year in Liverpool.

The public sector spending cuts as well as welfare and benefits reform experienced in Liverpool have impacted negatively on the health and wellbeing of our residents, particularly in regards to mental health, issues associated with food and fuel poverty, and indeed on overall mortality rates. This report has also uncovered evidence that it is residents living in our most deprived communities who have been disproportionally experiencing the associated health impacts of austerity which will only serve to exacerbate health inequalities within the city. Despite these challenges, the resilience of local people and their communities to the impact of austerity has been evident through joint working between communities, local groups and services across the public, third and independent sectors. These partnerships have been key to maximising support for the most vulnerable and disadvantaged by finding ways to ensure people continue to have access to key services as well as assistance to maximise incomes and opportunities for sustainable employment.

The health of the Liverpool population remains a major asset for the city in achieving its goals for economic growth and development. Health is therefore both a pre cursor and an outcome of wealth. It is the experience of austerity that highlights the importance of investing for sustainable health systems as a priority to achieving that continuous loop of growth in health alongside wealth. Economic growth and the success of the city is dependent upon the health of the population both in terms of providing an environment for children to have the best start in life, boosting employability and productivity of adults and enabling older people to sustain their good health for longer into older years; all of which enable improvements in health outcomes for the people of Liverpool.

Recommendations:

- To continue to monitor the impacts of austerity and welfare reform on the health and wellbeing of the population
- To monitor the recent increase in the city’s mortality rates and the consequent reduction in life expectancy.
- To investigate further the recent evidence of high rates of hospital admissions for malnutrition in women of child bearing age and children.
- To promote the presence of health in the development of policies across all aspects of service provision in the city.
- To continue to influence and promote prevention at the heart of all decision-making and policy development with health and social care providers.
• To continue to promote a whole systems approach to tackling the health and wellbeing issues highlighted in this report.

• For stakeholder engagement to play an increasing role in underpinning service design and re-development to ensure that services are responsive to people’s needs, preferences and expectations.
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