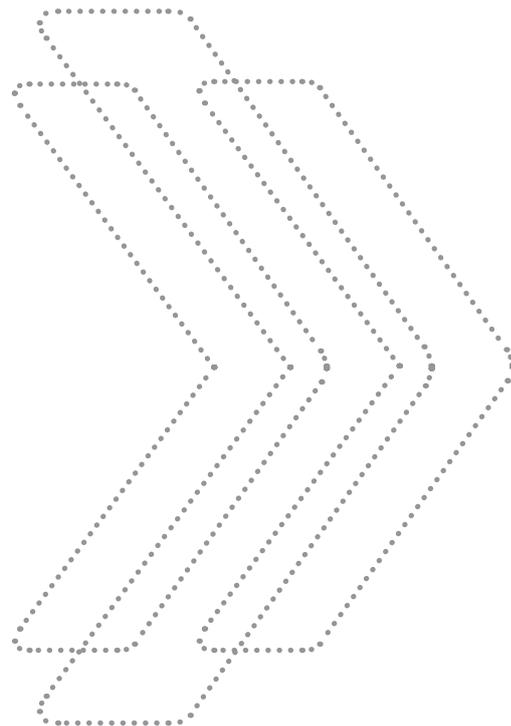

Tackling poverty: Making more of the NHS in England

Authors

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The research on which this paper is based was commissioned by the Joseph Rowntree Foundation (JRF) to inform its work to develop an anti-poverty strategy for the United Kingdom.



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The origins of this paper

The research on which this paper is based was commissioned from The King's Fund by the Joseph Rowntree Foundation (JRF) to inform its work to develop an anti-poverty strategy for the United Kingdom. The overarching question addressed is, how can the NHS make a better contribution to tackling poverty? We have interpreted this question to mean two things. First, how can the NHS – without structural reform – be incentivised and helped to do more to adapt, mitigate, reduce and prevent poverty? Second, what sort of things in practice would such an NHS be likely to be doing more of? We recognise the significant financial constraints on the NHS, and its local partners – particularly local government – but we do not focus on this specifically. Within whatever given funding levels, we believe the NHS can make an even greater contribution to tackling poverty than it already does.

A summary of all the research commissioned for JRF's anti-poverty strategy can be found at: www.jrf.org./topic/anti-poverty

Acknowledgements

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1. Introduction

As Nigel Lawson famously said, the NHS ‘is the closest thing the English have to a religion.’¹ The NHS remains highly prized, despite concerns about the impact of the NHS reforms and recent well-publicised issues of quality.²

Importantly for potential poverty reduction, the NHS has immense economic power as well as massive scale and reach in the population. As a country we are now spending more than £100 billion on the NHS in England,³ and there are more than 300 million consultations in general practice every year alone,⁴ and more in hospital and other community services.⁵

But it is far less clear that the most is being made of that potential in terms of the effect on poverty. This paper seeks to do six things.

- First, to set out the policy and financial context in which poverty is debated, if at all, in relation to the role of the NHS.
- Second, to provide an assessment of how well or poorly the NHS focuses and acts on poverty.
- Third, to assess the consequences of the government’s recent NHS reforms in England (in the context of wider government reforms) and whether they will impact positively or negatively on poverty.
- Fourth, to provide an analysis of where the leadership, incentive and allocation and system design features of the NHS can be better aligned to improve the chances of reducing or alleviating poverty. Essentially this will define what a ‘poverty-focused’ NHS needs to look like in terms of its overarching characteristics.
- Fifth, to set out what a poverty-focused NHS needs to be doing ‘more of’ in practice, based on a review of academic literature and practice – this will provide a future test of whether a more poverty-aligned system is delivering.

¹ Nigel Lawson, *Memoirs of a Tory Radical*, London: Bantam Press, p 613.

² <http://www.kingsfund.org.uk/projects/bsa-survey-2012>

³ <http://www.kingsfund.org.uk/blog/2013/10/what-are-we-spending-english-nhs>

⁴ http://data.gov.uk/dataset/trends_in_consultation_rates_in_general_practice

⁵ For the purposes of this report we do not cover privately funded health care. However, some services, notably dentistry and eye care health services, have a major privately funded component. Private insurance is also important for some groups, particularly as a perk for managers in large employers and there is a self-pay market for some health care. Poverty clearly put these services out of the reach of some people but entitlements mean that those in poverty do qualify for NHS dentistry and eye care.

- Finally, the paper concludes, and sets out recommendations and a future framework for the analysis of the impact of the NHS on poverty.

2. The NHS and poverty: the policy and financial context

Before we move to an overall assessment of the NHS's track record in tackling poverty, we need to set out the policy and financial context that surrounds the debate in this paper. We also need to situate this within certain boundaries – setting out what the analysis does and does not cover.

2.1 Should the NHS have a direct objective to reduce poverty?⁶

The commission for this paper is, how can the NHS better tackle poverty – not *whether* it should be expected, or asked directly, to do so. We believe that the NHS already tackles poverty, but it can do so more effectively than it does now.

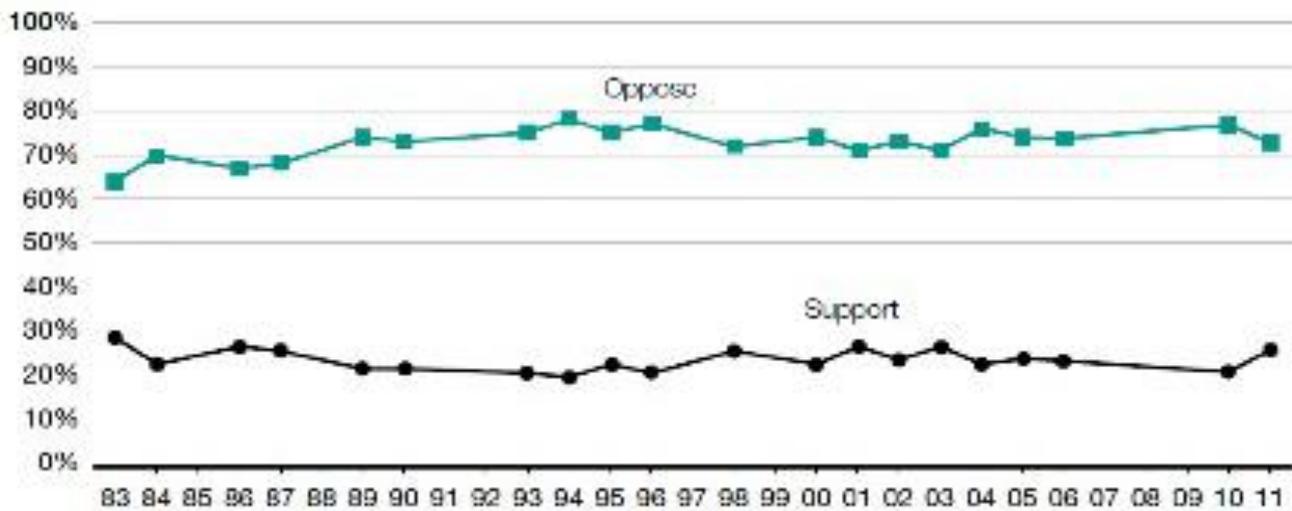
Nevertheless, any policy discussion of the NHS role in poverty needs to be set in the context of why the NHS exists as it does. The NHS is first and foremost a universal insurance system, necessary because free markets in health care (and health insurance) are not efficient or equitable. The efficiency of the NHS depends on its universality, creating a single risk pool and a powerful collective purchaser. Although this universal insurance is essential to prevent catastrophic illness, and therefore loss of income and poverty, its aim is not to reduce that poverty directly.

There are dangers of introducing a direct poverty reduction goal for the NHS. If taken to extremes, a focus on poverty reduction could undermine NHS efficiency as a universal risk pool. At the logical extreme, means-testing NHS services – as in social care – would be more pro-poor and redistributive but this would come at a very high cost: it would be a less efficient insurer with a narrower risk pool and would be politically unsustainable, as middle class taxpayers would remove consent. The NHS could in effect retreat to a safety net for the poor, rather than a universal system that aims to provide equitable service to all, regardless of means, be they high or low.

These arguments are not theoretical. Many other countries have more redistributive *public* health care systems than the NHS where access is restricted to the poor, alongside large private systems – the United States being the obvious example through Medicaid. Pushing for a direct objective to reduce poverty could therefore have unintended effects, if given the financial pressures on NHS funding, universality were at risk as a consequence. This universality is what sets the NHS apart from much of the rest of the welfare state. There is no appetite among the public to means test access to the NHS, with 7 in 10 people consistently opposing any move to make the NHS available only to those on lower incomes (Figure 1).

⁶ We are grateful to Joe Farrington-Douglas for raising this issue.

Figure 1: The public's views on restricting the NHS to those on lower incomes, 1983–2011



Source: BSAS health chapter 30 <http://www.bsa-30.natcen.ac.uk/downloads.aspx>

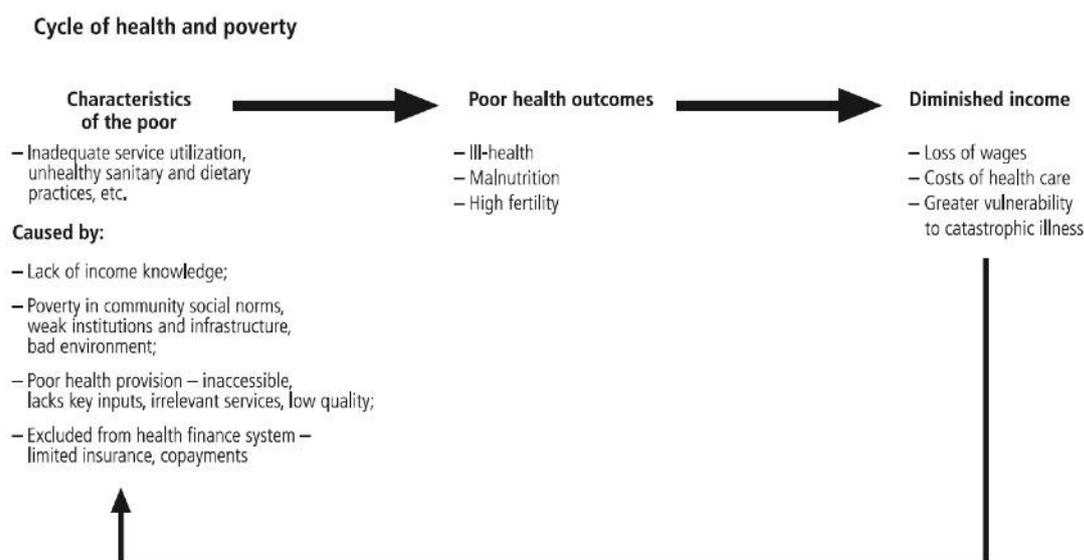
So to return to the question, our view is that the NHS should have a role in tackling poverty. We will show below that it already does, and we set out how *within its current objectives* it can be helped to do that better. But we do believe that including *direct* poverty reduction as a core objective of the NHS, if taken to extremes and if over-interpreted, threatens the sustainability of the NHS.

2.2 Tackling poverty vs tackling inequalities in health and health care

There are many competing ways to conceptualise how the NHS can better focus on poverty. Figure 2⁷ shows a representative ‘cycle’ of how poverty and health are contextualised from the economic development literature – with poor health connected to diminished income due to lower wages or no income, greater vulnerability and risk of catastrophic health care costs. This leads to poverty and greater susceptibility to poor health.

⁷ <http://www.scielosp.org/pdf/bwho/v80n2/a04v80n2.pdf>

Figure 2: The cycle of health and poverty



In more developed countries, health care and other welfare support systems attempt to break this cycle. This paper’s analysis will develop a more relevant framework for the impact of England’s NHS on poverty.

However, in England most analysis and debate about the NHS has not been focused on its role in tackling poverty, but on tackling inequalities between different groups, in terms of health outcomes and the ability to benefit from and access its services – including financial accessibility. Inequalities in this analysis are primarily defined as a relative concept across the spectrum of socio-economic status, and between different groups defined by gender, sexuality, disability or ethnicity. There are clear overlaps with concepts such as poverty (be that material, or in terms of other deficits including health), but it is different to current government definitions of poverty. Unlike poverty, there are no specific set benchmarks (such as being below 60 per cent of median income) since inequalities are construed as a condition *between* groups, and is not a concept that is attached to any individual.⁸

Therefore unlike poverty, no individual or family is ‘in health inequality’ or not. In essence, the debate on health and health care is focused on inequalities across the income distribution, rather than just on poverty at the bottom. That is partly because health inequalities affect all groups of society, not just those at the bottom, unlike other social problems like debt, fuel poverty, poor housing and unemployment tend to; and partly, as

⁸ For example, the current government definition of poverty is 60 per cent of median income, although the JRF and others have criticised this, whereas the last government’s focus on reduction in inequalities in health was defined in terms of ‘closing the gap’ in life expectancy between wealthier and poorer areas – not in terms of raising life expectancy in poor areas to any particular benchmark (be that relative or absolute).

stated above, the NHS has a universal remit, and therefore needs to weigh everyone's experience in the balance.

This distinction is important, particularly in how this has defined the policy goals of the NHS and the extent to which tackling inequality is synonymous with tackling poverty. For instance, an inequalities approach, of necessity, broadens the concerns about differences in outcomes and access to the whole population, but weakens the spotlight specifically on poverty.

This focus on inequalities rather than poverty is also reflected in the international literature on the comparative health and health care performance of developed nations. Further, much of health services research has analysed how the NHS can *adapt* its services to the needs of different groups in order to equalise access to the NHS, rather than to impact directly on changing poverty outcomes themselves, or the drivers of poverty such as unemployment and homelessness. Indirectly of course, adapting to the health needs of people in poverty may *mitigate, reduce* or *prevent* future poverty, but these have received little attention. The box below shows how these mechanisms to tackle poverty differ. In practice there is overlap, but it is a useful schema to conceptualise the NHS's actual and potential role.

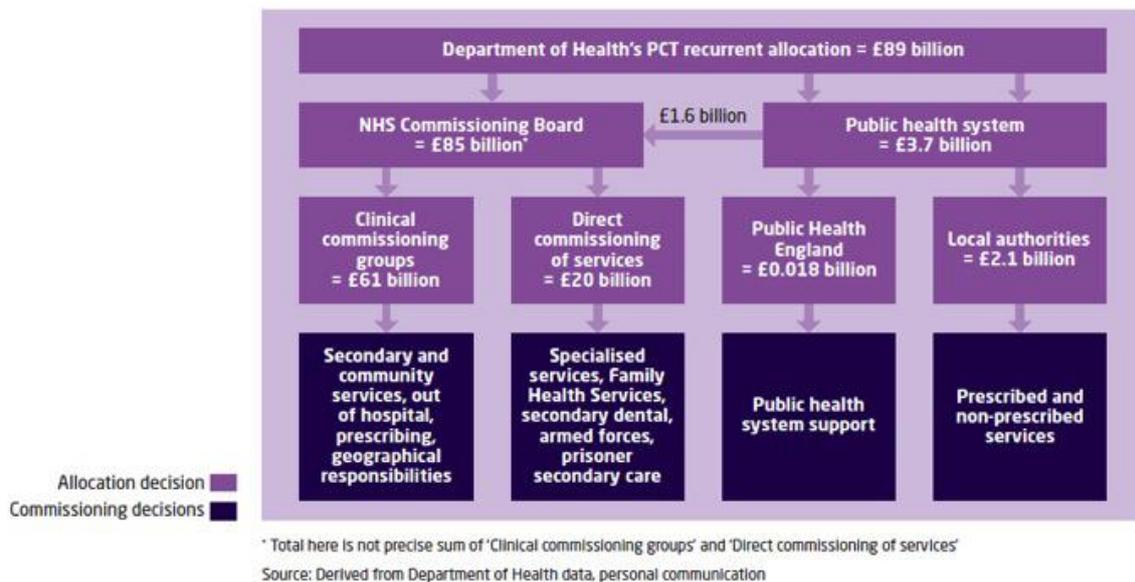
- **Adaptation** – ensuring that NHS services are available and accessible financially and physically for those in poverty
- **Mitigation** – how NHS services and wider actions may mitigate the impacts of poverty (for instance, insulating from debt due to free care entitlements or provision of access to debt counselling and other services)
- **Reduction** – how NHS services can lead to long-term 'escape' from poverty for individuals (for example, the receipt of health services as 'benefits in kind', acting as a counter to income inequalities) and for communities, through its status as a major economic system in all communities
- **Prevention** – either for an individual (for example, through supporting maintenance in well-paid employment) or inter-generationally (for instance, through the consequences for children's long-term economic prospects due to illness and disability)

2.3 Opportunity in crisis? The current financial context

The latest data on health spending in England shows that the Department of Health (DH) spent £104 billion in 2012-13, the vast majority used to pay for NHS services. Within this overall spend resources are distributed by the DH to itself (for central services), to NHS England (formerly the NHS Commissioning Board) to commission specialised services (those provided in relatively few specialist hospitals or for small numbers of patients, for example, specialist cardiac services and bone marrow transplantation)⁹ and primary care (including general practice, dentistry and ophthalmology); and to pass on to local clinical commissioning groups (CCGs) to purchase secondary care such as hospital and community services. The DH also funds the public health system, which is not the focus of this analysis.

The final flows of funds in the new post-NHS reforms system have not yet been reported, but Figure 3 shows an estimate from mid-2013 of how primary care trust allocations in 2010-11 would be 'redirected' under the reforms.¹⁰ The majority of funds flow to NHS England to be distributed to the new CCGs on the basis of a resource allocation formula that aims to reflect relative local needs for services based on age, gender and deprivation (for more on this see section 4.2).

Figure 3: NHS resource allocation under the new system architecture 2012/13



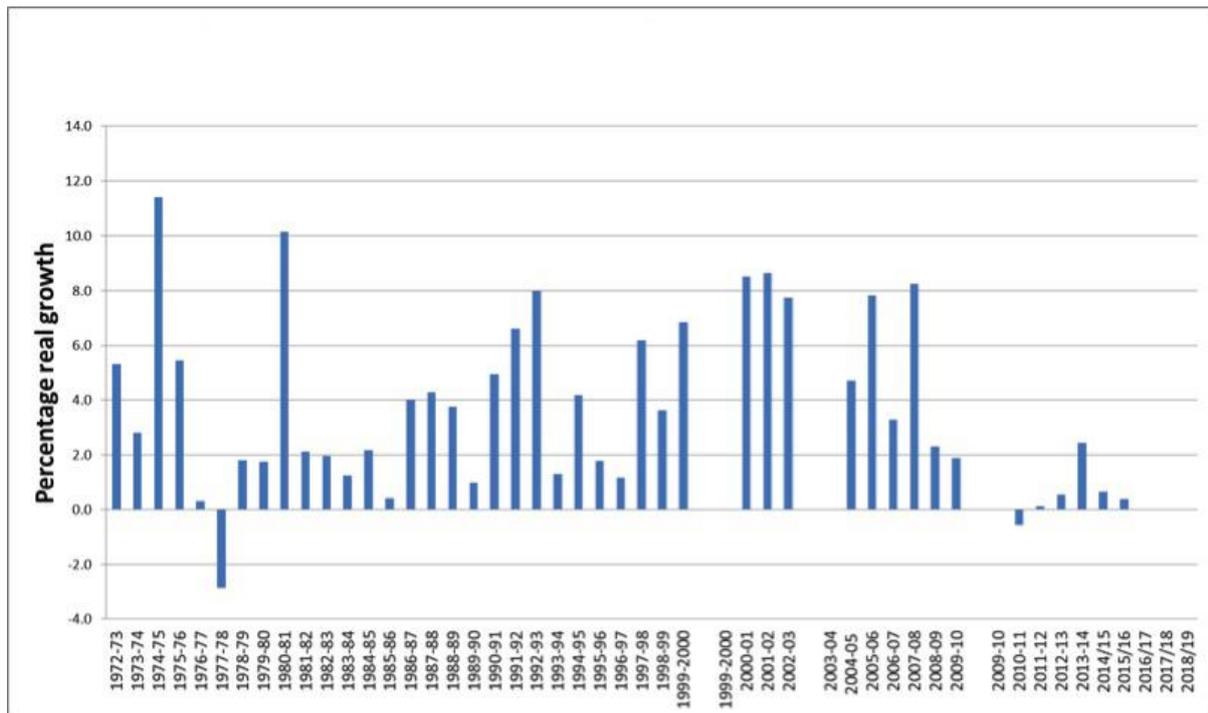
Source: <http://www.kingsfund.org.uk/publications/improving-allocation-health-resources-england>

⁹ For more on this see, <http://www.england.nhs.uk/ourwork/commissioning/spec-services/>

¹⁰ In reality, to this top-line allocation of £89 billion should be added the further budgets of Strategic Health Authorities (now abolished) and arms-length bodies (such as the major regulators, Monitor and the Care Quality Commission among others) – for a fuller analysis see, <http://www.kingsfund.org.uk/publications/improving-allocation-health-resources-england>.

The NHS is experiencing the longest period of funding restraint in its history. Figure 4 shows the pattern of year-on-year real terms increases in spending from 1971 to 2012-13 through to the planned spend from 2013-14 to 2015-16 and NHS England’s assumptions on the NHS budget from then on. There is very little or no growth, against increasing supply-side cost pressures of technological change, and rising and ageing populations.¹¹

Figure 4: Real growth in English NHS spending out-turn (1971–2013) and planned and assumed (2013–19)



Source: The King’s Fund analysis of Department of Health figures

(Note: There are breaks in the series, which make specific year-to-year comparisons unreliable.)

But other departments and local authorities are experiencing large real-terms cuts – for local government spending (excluding police, schools, housing benefit) is set to fall by nearly 30 per cent in real terms between 2008 and 2015.¹² Nor is this is not being spread evenly: the Institute for Fiscal Studies’ green budget for 2012 showed that the largest cuts were being felt in those areas with higher local authority spending, urban and more deprived areas, primarily, but not solely, in the north.¹³ This wider government spending slowdown is so large that even though real NHS funding has reached this unprecedented standstill, the

¹¹ <http://www.kingsfund.org.uk/publications/spending-health-and-social-care-over-next-50-years>

¹² <http://www.jrf.org.uk/sites/files/jrf/local-government-communities-full.pdf>

¹³ <http://www.ifs.org.uk/budgets/gb2012/12chap6.pdf>

Institute for Fiscal Studies estimates its share of overall of public funding will have risen from 13 per cent in the late 1970s to 28 per cent of government spending in 2014/15.¹⁴

This will affect the absolute numbers of people in poverty whom the NHS treats. It therefore needs to ensure even more that it is good at *adapting* to individuals in poverty who seek treatment. But it will also have an impact on the incentive and ability of the NHS on its own – and with partners – at a strategic level to tackle poverty. This can go one of two ways: firstly a retrenchment, a focus on each organisation’s own objectives and a reduction or delay in access expressed in waiting times, a rise in referral thresholds or types and intensities of treatment in the NHS. The other response is a re-imagining of services, seeing the silver lining in the cloud as an opportunity to reconfigure services, to integrate services around those with complex needs and, where it makes sense in terms of reducing duplication, improving co-ordination, outcomes and patient experience to bring together budgets, commissioning and provision between NHS, social care and other public services (see section 5.2.3 for more).

What we do not know, at present, is how these competing tensions will play out, or how exactly they are impacting on people in poverty. This paper’s focus is not to predict that outcome. Whatever the impact of these pressures, we believe that the NHS can do more to tackle poverty and we set out our reasoning in this paper.

2.4 The boundaries of the analysis: the NHS, public health and social care

There are three important areas that remain out of scope here. We explicitly do not cover social care or public health in any depth. Further, we do not consider any specific population sub-group for specific analysis – this paper is about how the NHS works at a system level, rather than for any single group.

However, we do discuss these issues at important points in what follows. The reality is that the boundaries between the NHS and the public health and social care systems are blurred. Indeed, The King’s Fund is separately looking again at the boundary between the NHS and social care in its Commission on The Future of Health and Social Care in England,¹⁵ and much of the current policy focus in health policy in England is on integrated care, ensuring that appropriate care is wrapped seamlessly around the individual, regardless of its definition as ‘health’ or ‘social’. Similarly, while recent health reforms¹⁶ have moved more public health funding and responsibility to local authorities, estimates suggest that about half of all ‘public health’, including important functions such as screening for disease and immunisation, are

¹⁴ <http://www.ifs.org.uk/publications/5651>

¹⁵ <http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england>

¹⁶ <http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/public-health-system/>

carried out in the NHS, through a complex array of commissioning routes.¹⁷ We take a pragmatic approach to these boundaries in what follows.

There are many specific sub-groups of the population, which in an expanded paper would merit a particular focus. Often these are groups described as ‘vulnerable’ in some way, such as homeless people, gypsies and travellers, or people with specific or severe disabilities. Again, this paper does not focus on any of these specific groups per se, but does refer to them at various points, for instance in section 6 in our review of case studies.

Finally, this paper focuses on the English NHS and the impact of the English reforms. Many of the issues will be similar across the United Kingdom, but systems do differ and that will affect how the NHS tackles poverty. This paper should therefore be useful to other nations, but needs to be interpreted in their context.

In conclusion, the NHS’s role in tackling poverty is complex, due to the NHS’s fundamental purpose and the current financial context both of the NHS and the wider services with which it interacts. But any system that is so deeply embedded in our lives and economy can do more to positively tackle poverty. The rest of this paper sets out some of the ways to achieve this.

3. An assessment of the current system

Our high-level assessment of how good the current system is in tackling poverty draws on international data, assessments and comparisons of our system against other comparable nations to assess how it adapts, mitigates, reduces and prevents poverty.

We first look at how the NHS adapts to poverty, in terms of financial access to care, how well it does in studies of international comparisons of equitable access, and in some specific areas and conditions through the course of a lifetime: in the early years and the experience of child poverty; in the working years and mental health; and in later years, and people’s experience of long-term conditions.

We then turn to a stronger focus on how the NHS mitigates, reduces and prevents poverty through its scale, scope and reach in society looking at the role of NHS services as ‘benefits in kind’ and how this affects income inequalities and the NHS as an employer, economic giant and commissioner.

3.1 Adapting to poverty

¹⁷

http://webarchive.nationalarchives.gov.uk/20130805112926/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216712/dh_131901.pdf

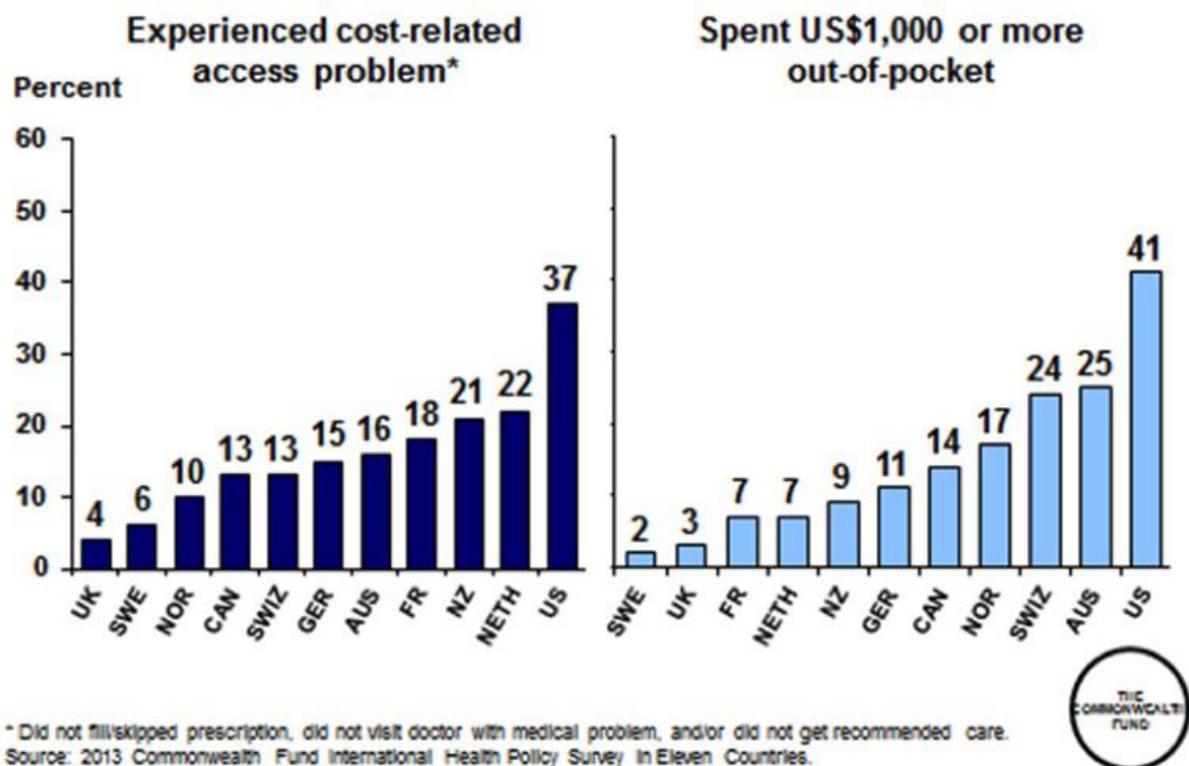
The NHS adapts to poverty as part of its universalism. Our current system, based on the twin high-level principles of tax-based funding and care free at the point of use, and of equity in provision mean that *in principle* the NHS is ‘well-adapted’ to poverty.

3.1.1 The NHS and financial access to care

The large majority of NHS care is tax-funded and where charges exist there are many exemptions. This first principle makes our system stand out internationally. Being unable to pay for health care has very significant effects on poverty in many other countries. For example, in the United States out-of-pocket health care expenses account for almost a quarter of income for those below the official poverty line¹⁸ and in many European social insurance systems, patients have to pay charges at the point of use, although much can be clawed back at a later date.

The NHS does consistently well in international comparisons of financial barriers to accessing health care (Figure 5), with fewer people reporting cost-related access barriers than our major comparator nations.¹⁹

Figure 5: Cost-related access barriers and out-of-pocket costs in the past year



¹⁸ C. De Navas-Walt, B.D. Proctor and C. Hill Lee (2006) ‘Income Poverty, and Health Insurance Coverage in the United States: 2005’, *Consumer Population Report*, US Census Bureau, August.

¹⁹ Source for figure, <http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Nov/Access-Affordability-and-Insurance.aspx>

Source: <http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Nov/Access-Affordability-and-Insurance.aspx>

Where there are charges, for example for dentistry, eye care or prescriptions there are many exemptions or reductions. For example, more than 90 per cent of prescriptions are exempt from charges due to severe need,²⁰ and there is other help available for instance on travel costs for those on low incomes and in receipt of benefits.²¹

However, work by the Citizen's Advice Bureau in the early 2000s found remaining charges are a problem for many of its clients,²² with around three-quarters of a million people a year estimated not to have fulfilled a prescription due to the cost. A later proposal²³ to waive prescription charges for all those with long-term conditions and those entitled to incapacity benefit without income support, contribution-based employment and support allowance, or disability living allowance was not adopted by the last Labour government.

Many families – for example those with severely disabled children – can also spend a high proportion of their incomes on aids, transport and accommodation costs which can push them into poverty.²⁴ Qualitative studies of parents of children with complex disabilities show that parents often stay with children undergoing tests or treatment and incur not just those costs but also of travel to and from home, care for children remaining at home, food and suitable clothing. A study for Scope²⁵ found that the average distance travelled by the families included was almost 4,000 miles per year.

Not everyone is entitled to free NHS care. There are current exceptions²⁶ including for some economic migrants, failed asylum seekers and 'over-stayers', some of whom will be in poverty. More broadly, there has also been recent discussion of introducing user charges in Accident and Emergency (A&E),²⁷ GP visits and other areas.²⁸ There is currently little appetite among the mainstream of any of the main parties to consider this. However, this cannot be ruled out in future, given the squeeze on NHS finances and an environment where health care benefits to some migrants are being restricted.²⁹

²⁰ <http://www.hscic.gov.uk/catalogue/PUB11291>

²¹ <http://www.nhs.uk/NHSEngland/Healthcosts/Pages/nhs-low-income-scheme.aspx>

²² http://www.citizensadvice.org.uk/index/policy/policy_publications/unhealthy-charges.htm

²³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213884/dh_116367.pdf

²⁴ Baumberg *et al* 2014, report for JRF Anti-Poverty Strategy Programme, unpublished.

²⁵ http://www.scope.org.uk/sites/default/files/Scope_Keep_Us_Close_policy_report_final.pdf

²⁶

http://www.adviceguide.org.uk/england/healthcare_e/healthcare_help_with_health_costs_e/nhs_charges_for_people_from_abroad.htm

²⁷ <http://www.dailymail.co.uk/news/article-2532989/Charge-10-A-E-visits-say-GPs-Doctors-want-impose-basic-fee-deter-patients-turning-trivial-complaints.html>

²⁸

http://www.reform.co.uk/resources/0000/1069/The_cost_of_our_health__the_role_of_charging_in_healthcare.pdf

²⁹ <http://www.telegraph.co.uk/news/uknews/immigration/10358569/End-of-free-NHS-care-for-migrants-under-new-bill.html>

Finally, there are also under-recognised opportunity costs of attending for treatment, which can be more significant for those in, or at risk of, poverty than for the population as a whole. This could be one reason for the well-established fact that attendance rates for many NHS services – including mental health³⁰ – are lower in more deprived areas and for more deprived patients than for the population as a whole. Where people have a crisis in their lives, attending GP appointments will not be a priority.³¹ Opportunity costs of attendance are also more likely to be problematic for those suffering in-work poverty and in lower-paid jobs where absence from work results in penalties to wages or salaries.

3.1.2 The NHS and inequalities in access to care

The second principle, that of equity in provision – that is, each patient should be treated equally according to need (horizontal equity) and more needy patients receive more care (vertical equity) – is the other core driving principle of the NHS. This is stated clearly and strongly in the NHS constitution.³² For those in poverty, this principle – getting the right care at the right time, with the right intensity – is just as important as the first, on access to care being free at the point of use.

When set against comparable health care systems, the NHS comes out very well on important indicators of equity in provision.³³ Figure 6 shows whether – controlling for estimated need³⁴ – the probability of visiting a GP or specialist is determined by relative income. The United Kingdom³⁵ is class-leading in GP visits, in that it is essentially ‘income-blind’, and with the Netherlands it is by far the least pro-rich among all comparator nations in terms of access to specialists. The United Kingdom also performs well internationally in terms of the number of visits, as Figure 7 shows. Although there is a slight pro-rich bias, this is lower than other countries.

³⁰ <http://apt.rcpsych.org/content/13/6/423.full#ref-87>

³¹ <http://fampra.oxfordjournals.org/content/17/3/252.full.pdf+html>

³²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

³³ <http://www.cmaj.ca/content/174/2/177.full.pdf>

³⁴ The data was standardised for age, gender and reported health levels as proxies for need.

³⁵ Although the focus here is on England, many cross-national comparisons take the United Kingdom as the unit of analysis, since this is the level at which most of the data is collected by the WHO, OECD and other international bodies, upon which much of the analysis depends.

Figure 6: Horizontal inequity indices for annual probability of visiting a GP in 21 OECD countries

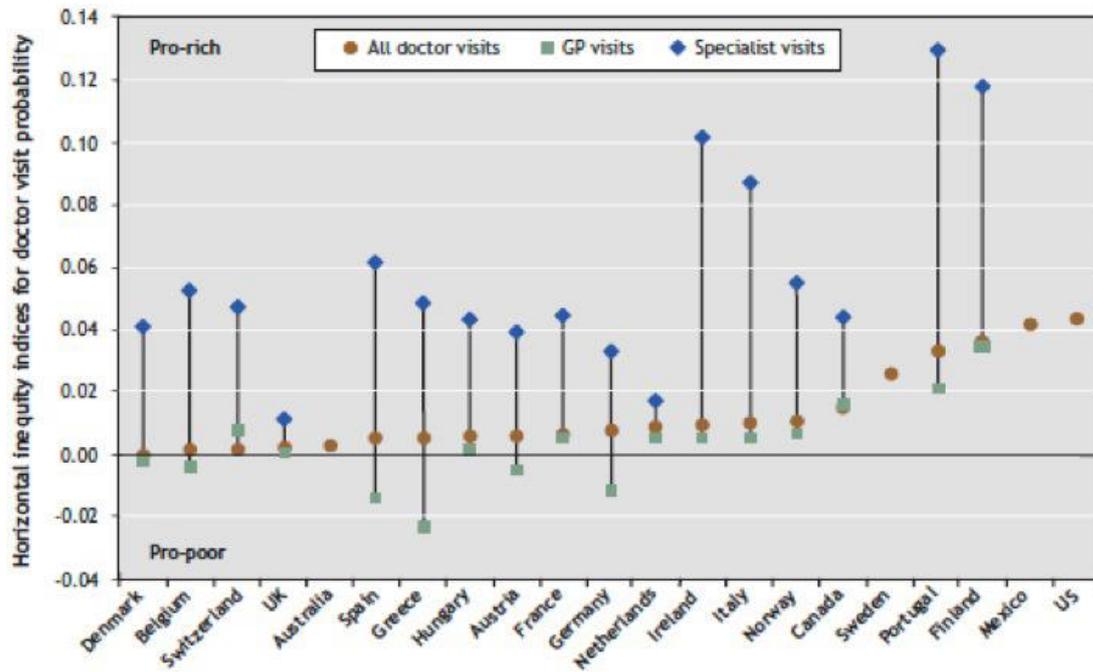
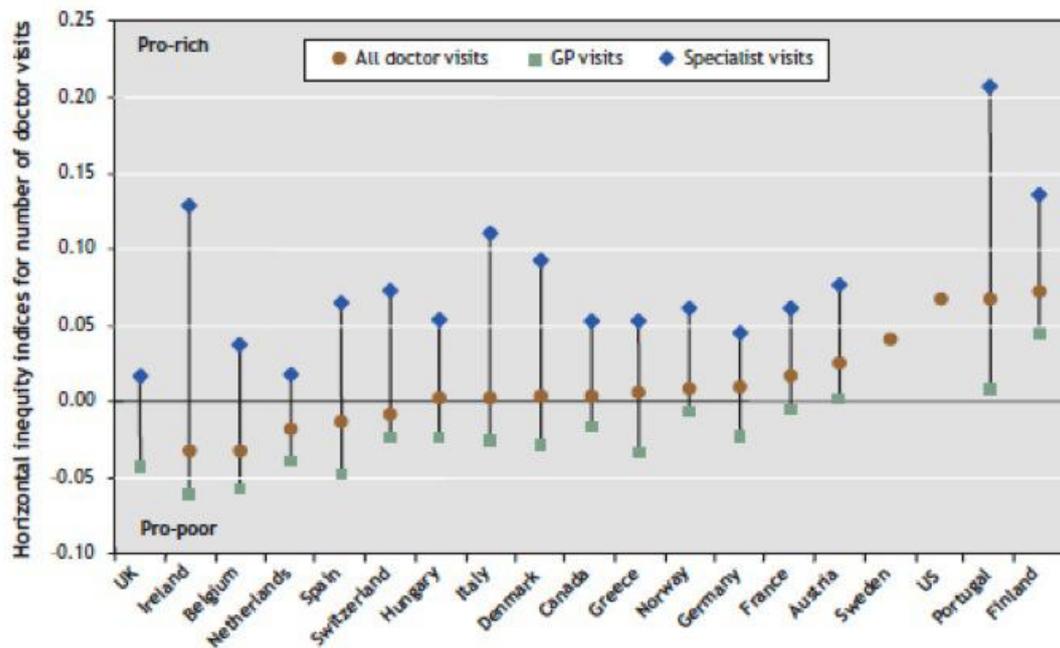


Figure 7: Horizontal inequity indices in number of annual GP and specialist visits



Source: <http://www.cmaj.ca/content/174/2/177.full.pdf>

More specific analysis within the NHS also shows it performs well on access for some patient characteristics closely associated with a higher likelihood of poverty. For instance, several studies from the United Kingdom have shown that ethnic minorities – who as a whole³⁶ constitute a group at greater risk of poverty – make greater use of primary care, even after adjustment for self-reported health. The most comprehensive analysis³⁷ of the Health Survey for England reaffirms greater use of primary care, and no differences from the majority population in some important outcomes from care, for hypertension, cholesterol or overall outcomes from diabetes care.

However, the same study shows this greater use of primary care for many ethnic groups is not reflected in greater use of secondary care or follow-up services, and also shows ethnic inequalities in access to hospital services, and marked inequalities in use of dental care. Even though use of primary care is higher, the experience and satisfaction with care is generally lower, for instance in terms of longer waits for appointments.³⁸ Therefore, although primary care performs well compared to other nations, simply having a universal primary care-focused health care system is not sufficient on its own to ensure that access to NHS care is equitable. Other groups where access to care is unjustifiably poor include homeless people, gypsies and travellers, sex workers and vulnerable migrants.^{39, 40}

In general there remains widely known unjustifiable variation – or inequality – in access and outcomes of NHS care. This is recorded in many documents from think-tanks,⁴¹ academics and the NHS itself, particularly in its collection of NHS Atlases of Variation⁴² in areas such as diagnostic services, diabetes and young children’s health, among others. It is not feasible to document all this variation here, and not all relates to poverty. However, three areas over a lifetime are of particular importance and relevance: the early years, mental health, and in later life, long-term conditions.

3.1.3 The NHS and the early years

There is now incontrovertible evidence that our experiences in the early years (and in the nine months before birth) have lasting consequences for our economic and wider life chances. The NHS therefore has a core role to play. *Fair Society, Healthy Lives*,⁴³ the reports

³⁶ However, there are significant differences between ethnic groups. See

<http://www.jrf.org.uk/sites/files/jrf/poverty-ethnicity-evidence-summary.pdf>

³⁷ <http://jech.bmj.com/content/63/12/1022.full.pdf+html>

³⁸ <https://www.britac.ac.uk/templates/asset-relay.cfm?frmAssetFileID=13284>

³⁹ <http://webarchive.nationalarchives.gov.uk/http://www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf>

⁴⁰

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287787/JSNA_and_JHWS_guide_-_FINAL.pdf

⁴¹ For example, <http://www.kingsfund.org.uk/publications/variations-health-care> and <http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice>

⁴² <http://www.rightcare.nhs.uk/index.php/nhs-atlas/>

⁴³ <http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review>

by Graham Allen^{44, 45} on investing in the early years, and the 2012 Chief Medical Officer's report on prevention in childhood,⁴⁶ set out all the relevant and compelling evidence. The NHS Atlas of Variation in Health Care for Children and Young People shows how access to care varies significantly depending on geography.⁴⁷

Nonetheless, most of the research effort has been directed at how poverty and low income affects children's health and cognitive development with long-lasting implications for success in later life,⁴⁸ rather than how NHS services actually act to reduce the poverty of children, or mitigate its effects. Important exceptions to this are initiatives of the Scottish and English governments – *Healthier, Wealthier Children*^{49,50} in Glasgow and in England the Family Nurse Partnership (FNP).⁵¹

Case study: NHS Greater Glasgow and Clyde – Healthier, Wealthier Children⁵²

The purpose of the project is to test whether there are unmet financial inclusion needs for families with children involved with the NHS and to mainstream an approach to this.

It offers income maximisation advice for families experiencing child poverty and will aim to prevent families from falling into child poverty by working with health and early years services to identify families at risk at an early stage. Consequently the main service groups targeted for providing referrals to Healthier, Wealthier Children income maximisation services include midwives and other antenatal service staff, health visitors, oral health and breastfeeding advisers, and parenting support workers.

Health staff referred parents through to Money Advice Services. Health workers have roles in:

- facilitating a strategic approach to financial inclusion for children and families at a local level
- identifying referral routes
- providing awareness and training sessions
- facilitating innovative practice (for instance, adapting group work interventions to cover financial capability)

⁴⁴

<http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf>

⁴⁵ <https://www.gov.uk/government/news/graham-allen-launches-second-report-on-early-intervention>

⁴⁶

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf

⁴⁷ <http://www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults/>

⁴⁸ <http://www.nhsggc.org.uk/content/default.asp?page=s1652>

⁴⁹ <http://www.hsj.co.uk/resource-centre/best-practice/public-health-resources/nhs-innovations-on-child-povertyfinancial-inclusion-interventions/5046943.article#.UyHG-YVWPOU>

⁵⁰ <http://www.equalitiesinhealth.org/documents/HealthBenefitsofFIfinalreport.pdf>

⁵¹ <http://fnp.nhs.uk/>

⁵² Drawn from <http://www.hsj.co.uk/resource-centre/best-practice/public-health-resources/nhs-innovations-on-child-povertyfinancial-inclusion-interventions/5046943.article#.UyHG-YVWPOU>

- collating evidence of mainstreaming activity.

Money Advice Services had roles in:

- welfare benefits check with particular specialism in children and families benefits
- support with benefits crisis loans applications etc.
- advice and onward referral.

Initial impact

- There were 2,516 referrals to local advice services from October 2010 to January 2012, with an overall annual financial gain in excess of £2.25 million for those accessing advice services.
- A consensus that the majority of families would not have found their way traditionally to Money Advice Services as these types of services are usually accessed when a major financial crisis looms. Traditionally, they also have limited outreach locations.
- The most prevalent model in NHS Scotland in signposting to Money Advice Services. However, patients with multiple and complex needs are unlikely to access signposted services because of stigma. Making direct referrals to Money Advice Services appears a more efficient and valued approach by patients.
- Examples include better uptake of Healthy Start vouchers and vitamins (a pregnancy passport welfare benefit, which has been associated with national and local implementation challenges). A significant feature has been Child DLA claims – for example, one client had £17,000 backdated in Child DLA).

Evaluation

- Since the project launch in October 2010 to March 2013, a cumulative total of 5,003 referrals led to just over £4.5 million in annual financial gain for those who accessed the advice service.
- The majority of referrals to advice services were from health visitors (41 per cent) and midwives (14 per cent). Other referrals included primary care staff (8 per cent) and ad hoc sources (19 per cent), primarily social work staff.
- Referring pregnant women and families to mainstream advice services resulted in a 45 per cent (1,027 / 2,289) uptake of advice.
- Household data, recorded for 1,021 of the 2,487 advice clients, revealed that the majority (69 per cent; 703/1,021) were lone parents.

More details, models and further case studies can be found at www.nhsggc.org.uk/content/default.asp?page=home_hwc

An evaluation report of services to early 2012 at www.gcph.co.uk/assets/0000/3649/HWC_final_report_FINAL.pdf and from March 2012 to March 2013 at www.gcph.co.uk/publications/457_healthier_wealthier_children_phase_two_evaluation

The Glasgow initiative (see box) used early years staff to identify, intervene and refer parents on who were in, or at risk of, experiencing child poverty. It used health visitors, antenatal and other staff to identify poverty problems and refer on to money advice services. Since the project launch in October 2010, a cumulative total of 5,003 referrals have resulted in just over £4.5 million in annual financial gain for those who accessed advice services.

In England, the FNP has not had such an explicit focus on poverty reduction – although 85 per cent of its enrollees have incomes below the poverty line. Rather its focus is to improve long-term outcomes for vulnerable, first-time young mothers through intensive support.

The evidence base for the FNP^{53,54} is strong and growing for both mothers and children, including long-term improvements in mental and behavioural health, greater school readiness, fewer child injuries and reductions in crime. There is also evidence of reductions in welfare and other government assistance payments, increased father presence and stability, and greater maternal employment, and by inference, a reduction in child poverty. By March 2013, the FNP was being delivered in more than 90 communities in England, offering in excess of 11,000 places at any one time. The government has committed to raising this to 16,000 by April 2015.

3.1.4 The NHS and mental health

There are clear issues of access to appropriate NHS care in mental health services. It is estimated that approximately 70 per cent of individuals with psychotic disorders are economically inactive⁵⁵ while people with common mental disorders such as depression experience some of the highest rates of absence from work, premature retirement and long-term unemployment.⁵⁶ Therefore people with mental health problems are at greater risk of poverty, and correspondingly it is important that the NHS is effective in meeting and adapting to the health needs of this group.

⁵³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215542/dh_128008.pdf

⁵⁴ Also see the review for the Northern Ireland government:

http://www.ofmdfmni.gov.uk/best_practice_in_addressing_child_poverty_september_2013.pdf

⁵⁵ The Sainsbury Centre for Mental Health (2003) *The economic and social costs of mental illness*. Policy paper 3.

⁵⁶ D. McDaid, M. Knapp, H. Medeiros and the MHEEN Group (2008) *Employment and mental health: Assessing the economic impact and the case for intervention*.

Access to NHS care for those with mental health problems is complex. Many issues reflect those experienced by others with long-term conditions (see next section) as well as issues such as homelessness which may be a result of, or be compounded by, mental ill health. There are three areas of particular concern where the NHS can do more to tackle poverty through its impact on mental health: access to evidence-based mental health interventions, particularly in primary care; appropriate pathways of access to secondary care for black and minority ethnic groups; and access to appropriate physical health care.

According to the 2007 Psychiatric Morbidity Survey, only 24 per cent of those with depression and anxiety disorders were in any form of treatment, and of these, only 2 per cent were getting the NICE-recommended therapy intervention.⁵⁷ This group is mainly seen within primary care settings and is under-served in terms of access to appropriate interventions. Despite welcome investment in provision through the Improving Access to Psychological Therapies programme (IAPT),⁵⁸ implementation has been insufficient to meet demand and a number of services have been cut in recent years. A report conducted by the Centre for Economic Performance⁵⁹ concluded that in many regions the money provided for growth of IAPT has not been used for its intended purpose, resulting in a failure to meet the original targets for the number of people who would recover, while disparities in access for people from black and minority ethnic backgrounds, young people and older adults remain.

One of the core guiding principles of the Mental Health Act (2007)⁶⁰ is the requirement that treatment for people with limited capacity be provided in the least restrictive environment. Yet there is a disproportionate number of people from black and minority ethnic communities subject to coercion under the Mental Health Act, treated within acute and forensic mental health services where they are more likely to be exposed to forced medication and restraint.⁶¹ The 2011 *Count Me In*⁶² census showed a two to six times higher likelihood of admission from a Community Treatment Order in black and minority ethnic groups than the average, and higher lengths of stay. Rates of mental illness in this group are driven by socio-economic factors with those coming from poorer backgrounds, living in inner cities and encountering adversity and discrimination at particular risk. The reasons for these high rates of coercion are complex. But despite a focus on black and minority ethnic communities, there has been little progress in improving the outcomes and satisfaction of

⁵⁷ Centre for Economic Performance's Mental Health Policy Group (2008) *How mental illness loses out in the NHS*.

⁵⁸ <http://www.iapt.nhs.uk/>

⁵⁹ Centre for Economic Performance's Mental Health Policy Group (2008) *How mental illness loses out in the NHS*.

⁶⁰ The Mental Health Act 2007 (c.12) London: The Stationery Office
<http://www.legislation.gov.uk/ukpga/2007/12/contents>

⁶¹ The Schizophrenia Commission (2012) *The abandoned illness: a report from the Schizophrenia Commission*. London: Rethink Mental Illness

⁶² http://www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf

these groups with services.⁶³ As the NHS Confederation acknowledges,⁶⁴ the NHS needs to do more to support race equality in the NHS, particularly for mental health.

Finally, the impact of mental illness on physical health is well established. Antipsychotic medications contribute to higher rates of obesity,⁶⁵ there are lower rates of exercise in people with mental illness⁶⁶ and they are far more likely to smoke, with more than 40 per cent of all tobacco in England smoked by this group, further exacerbating poverty.⁶⁷ All this contributes to a life expectancy of 15 to 20 years less than the general population. However, the National Audit of Schizophrenia showed poor rates of routine monitoring by health professionals with fewer than 30 per cent of people with schizophrenia receiving an annual health check.⁶⁸ Another report showed that people with mental health problems are significantly less likely to be offered help and support to quit.⁶⁹ Many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health and they are not offered access to NICE-recommended interventions.⁷⁰

3.1.5 The NHS and long-term conditions

A further area, and clear policy priority, where the links with inequalities and poverty have been greatly neglected is how the NHS deals with the prevention and treatment of long-term conditions. Long-term conditions (LTCs) are defined simply as persistent health issues that cannot be cured but can be controlled – to some extent – by medication or other intervention including lifestyle changes and adapting a patient’s environments and wider lives. Examples include physical conditions such as arthritis and high blood pressure and mental health issues including, depression and dementia. More than 15 million people, 3 in every 10 of us in England, have an LTC. Care for people with LTCs accounts for 70 per cent of the health and social care budget in England. Increasingly people are experiencing more than one LTC at a time which complicates care and treatment, and raises costs: by 2018 2.8 million people in England will have three or more LTCs, compared to 1.9 million in 2008.⁷¹

⁶³ The Schizophrenia Commission (2012) *The abandoned illness: a report from the Schizophrenia Commission*. London: Rethink Mental Illness

⁶⁴

http://www.nhsconfed.org/Publications/Documents/Race_equality_in_mental_health_final_for_website_8_May.pdf

⁶⁵ SL McElroy (2009) ‘Obesity in patients with severe mental illness: an overview and management’. *Journal of Clinical Psychiatry* 70 s3: 12-21.

⁶⁶ S Brown, J Birtwistle, L Roe, C Thompson (1999) ‘The unhealthy lifestyle of people with schizophrenia’. *Psychol Med* 29: 697-701.

⁶⁷ S McManus, H Meltzer, J Campion (2010) *Cigarette smoking and mental health in England*. Data from the Adult Psychiatric Morbidity Survey. London: National Centre for Social Research.

⁶⁸ Royal College of Psychiatrists (2012) *Report of the National Audit of Schizophrenia (NAS) 2012*. London: Healthcare Quality Improvement Partnership.

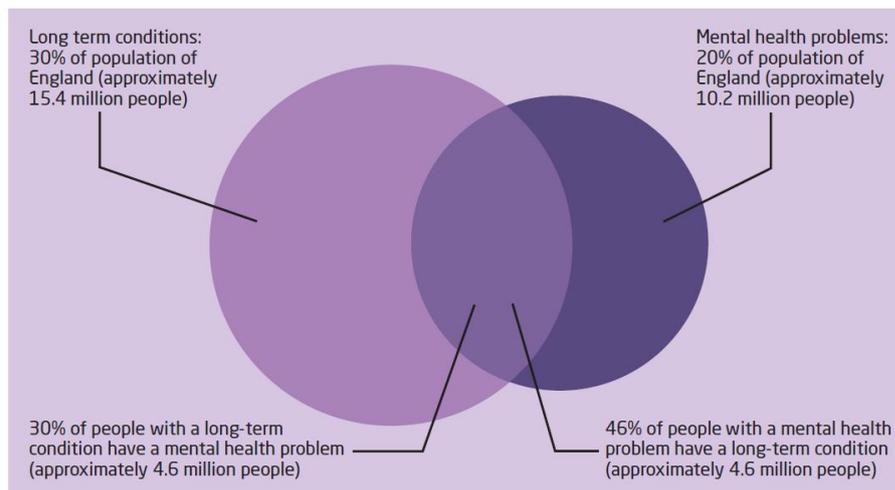
⁶⁹ NHS Smokefree London (2001) *Smoking and mental health*. Symposium report. www.ash.org.uk

⁷⁰ Rethink Mental Illness (2013) *Lethal discrimination: Why people with mental illness are dying needlessly and what needs to change*. London: Rethink Mental Illness.

⁷¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

There is an increasing awareness that people with LTCs are two to three times more likely to experience mental health problems (Figure 8), this raises health care costs by at least 45 per cent, suggesting that between £8 billion and £13 billion of NHS expenditure on LTCs is linked to poor mental health.⁷²

Figure 8: The relationship between mental health and long-term conditions

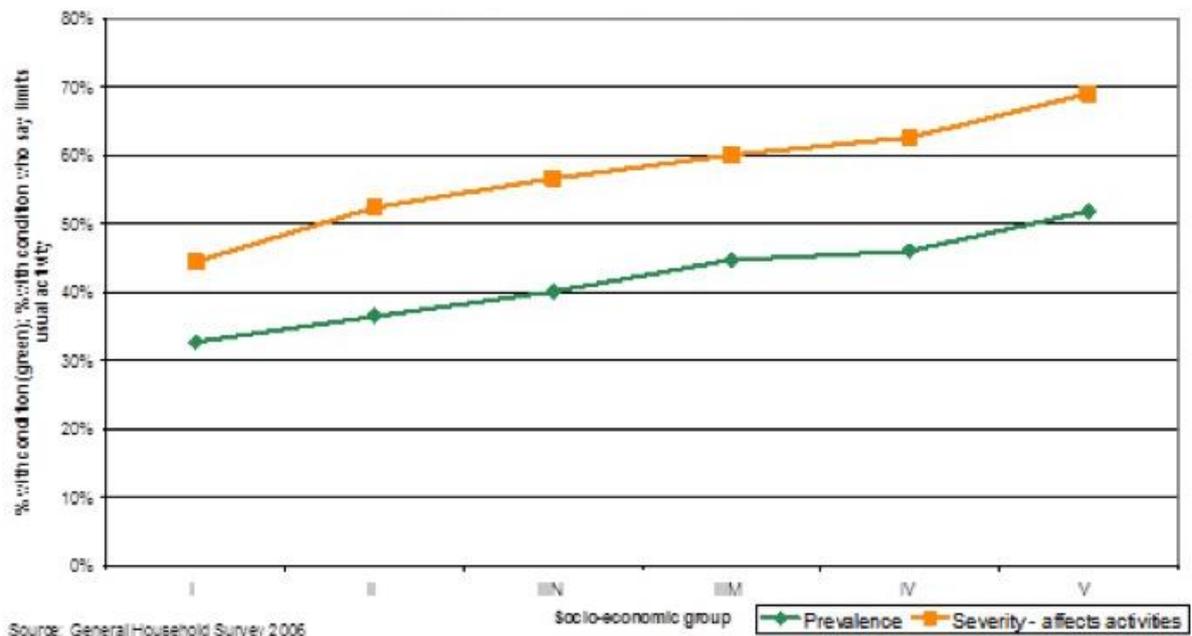


Source: <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

What is less well-known, or reflected in policy, debate or practice overall in the NHS, is how socially skewed experience of LTCs is. Those from lower socio-economic groups are much more likely to experience them, and to experience them more severely as a whole (Figure 9) although the relationship between socio-economic circumstances and individual conditions varies (Figure 10).

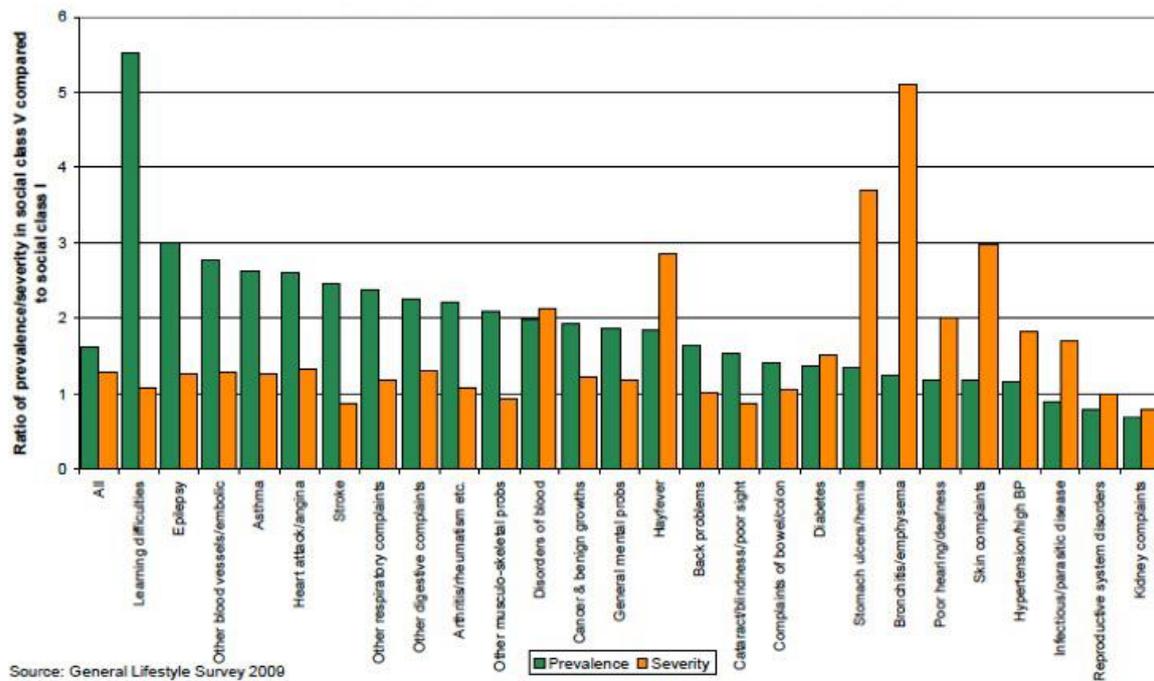
⁷² http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

Figure 9: Link between socio-economic group and LTC prevalence and severity*



*I refers to the highest socio-economic group, V the lowest

Figure 10: Inequalities in LTCs: severity and prevalence in social class I compared to social class V

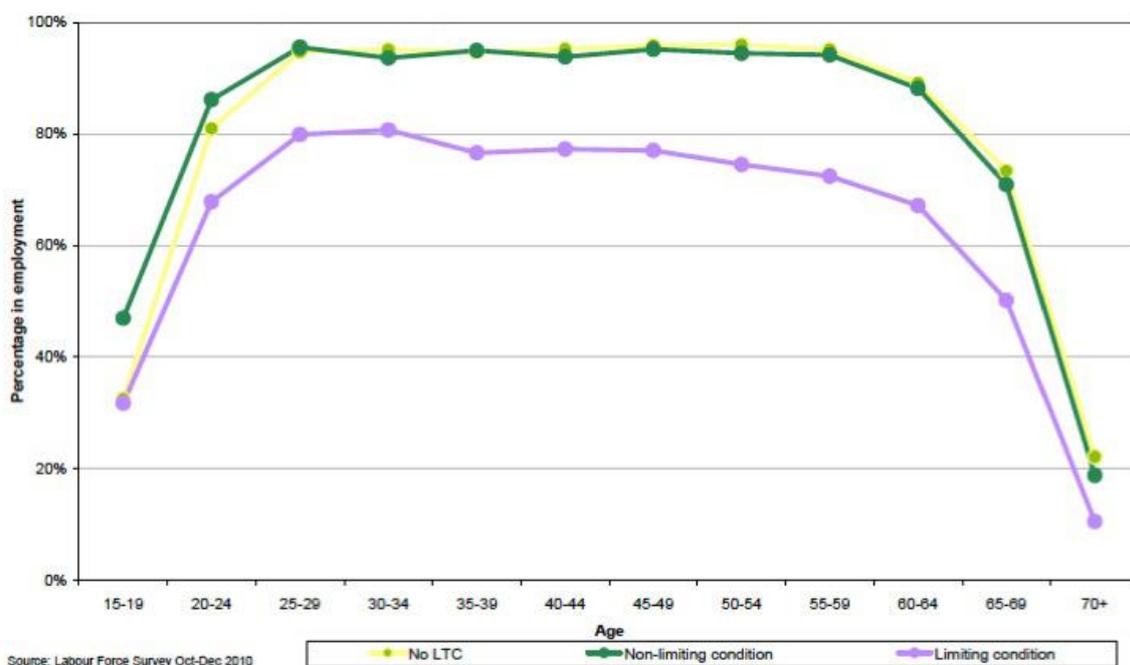


Source: Department of Health analysis, unpublished.

Recent evidence⁷³ using data from almost 500 general practices shows that rising deprivation channels more people into having multiple LTCs, as opposed to single or no LTCs; 1 in 3 patients from the most deprived postcodes have 3 or more LTCs, compared to only 7 per cent from the least deprived. This systematic social patterning means that the NHS needs to be alive to the social status and context of its 15 million patients with LTCs.

As LTCs are also by definition conditions that people live with every day, they have a direct impact on patients as people, as employees and in terms of their economic status. In particular, LTCs are closely associated with labour market status. We know that earlier onset of LTCs – itself linked to socio-economic status – is linked to reduced likelihood to enter and earlier exit from the labour market if the LTC limits everyday activities as Figure 11 shows. Overall, more than half of those with an LTC consider their health is a barrier to the type or amount of work they can do, rising to more than 80 per cent when someone has 3 or more conditions.

Figure 11: Employment rate by age and whether person has an LTC



Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

Michael Marmot has made a similar point in *Fair Society, Healthy Lives*⁷⁴ showing how raising the pension age will lead to more people with LTCs being eligible for employment,

⁷³ <http://hsr.sagepub.com/content/18/4/215.full.pdf+html>

⁷⁴ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

but questioning just how many will be able to participate, leading to income pressures on the individual and cost pressures on the state.

LTCs are therefore likely to be a core factor that keeps people on lower incomes and in poverty, and in propelling people into increasing unemployment, compromising individual and family income levels and increasing poverty risk. The trend is for this to become more of an issue over time as the population ages, and as government reforms in other areas take effect. How the NHS ‘adapts’ to the increasing number of people with LTCs and co-morbid mental health problems is clearly very important for the knock-on implications for reducing the risk of poverty.

3.1.6 Summary

In summary, in terms of NHS adaptation to poverty,

- There are two key indicators of importance for those in poverty: being financially able to access care, and being able to access the right amount of care relative to need.

International comparisons

- The public report very low rates of not being able to access required health care due to financial barriers. This contrasts sharply with many other developed countries.
- After adjusting for indicators of need the NHS also appears remarkably ‘income blind’, especially in terms of access to general practice services and, with the Netherlands, is much less pro-rich than other developed countries in terms of access to specialist services.

Within England

- Analysis *within* England (or the United Kingdom) however shows a more mixed picture. Despite the presence of exemptions and grants, many people struggle to pay prescription charges, and travel and other costs can be prohibitive for those with, or with family members with, severe disabilities.
- For some groups more likely to be in poverty – such as black and minority ethnic groups – access to primary care services is overall good, but access to other services such as dentistry, and acute care, is less so. Actual experience of care can be worse, even though access is greater.
- For some core conditions we know that the NHS can do better, particularly in terms of its support for families at risk of or experiencing child poverty, those with mental health problems and those with long-term conditions – often the same people. This has

implications for these people's presence in the workforce, where economic inactivity is a significant risk for poverty.

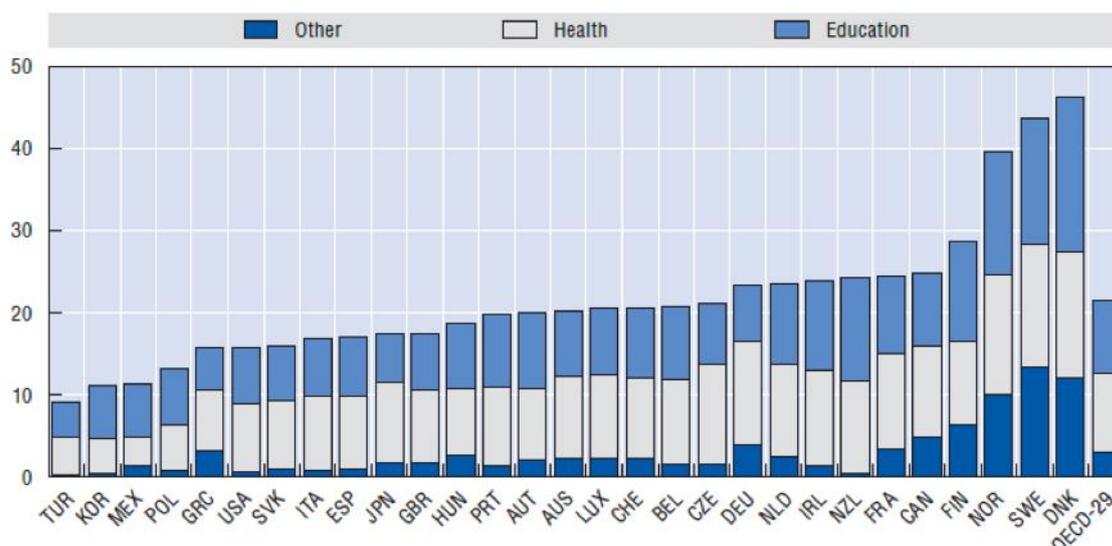
3.2 The wider impact of the NHS

There is a good case for arguing that the NHS is fundamentally well-designed to *adapt* to poverty, particularly in terms of financial access to care, although in practice it can always do better. We argue that the NHS and its leaders and policy-makers are much less well aware of, and therefore less attuned to, its role in mitigating, reducing or preventing poverty outside the delivery of specific health care treatments. But this is a major oversight. The NHS acts in effect to dampen income inequalities and in addition impacts on poverty through its role as employer, its economic presence in all local economies and as a commissioner.

3.2.1 NHS benefits in kind and income inequalities

One powerful way in which the NHS already acts to reduce poverty is its role in mitigating the impact of income inequalities. Poorer people need and receive health care services more due to greater health needs. NHS services can be seen as the transfer of free services in kind, which without the NHS would need to be paid for directly. Looked at this way across the OECD, government in-kind expenditure accounts for around 21 per cent of disposable income, of which health care, at 45 per cent is the biggest component, closely followed by education (Figure 12).

Figure 12: Public expenditure for in-kind services in OECD countries in 2000



StatLink <http://dx.doi.org/10.1787/423415168781>

Note: The category "other social expenditure" includes services to the elderly, survivors, disabled persons, families and unemployed, as well as those related to housing, social assistance, and active labour-market policies.

Source: Data are taken from the OECD database on social expenditure for the "health" and "other social expenditure" categories, and from the UNESCO-OECD-Eurostat database for education expenditure. For Turkey, data refer to 1999. Household disposable income is taken from the national accounts for all the countries considered except Ireland and Luxembourg (where no national accounts data for the household sector exist), where data are drawn from the OECD questionnaire on income distribution.

Source: http://www.oecd-ilibrary.org/social-issues-migration-health/the-impact-of-publicly-provided-services-on-the-distribution-of-resources_5k9h363c5szq-en

Most studies tend to show that the redistributive effects of health care towards lower income groups are higher in countries with more restricted access to publicly funded health care, such as the United States, since services are targeted strongly towards low-income and other groups. Ironically, in more universal systems where everyone benefits by definition, such as the NHS, distributional effects are not so strong, but remain significant.

The OECD has reviewed⁷⁵ and updated estimates of how health care and other public services are redistributed across income quintiles across countries.⁷⁶

⁷⁵ http://www.oecd-ilibrary.org/social-issues-migration-health/the-impact-of-publicly-provided-services-on-the-distribution-of-resources_5k9h363c5szq-en

⁷⁶ There are methodological issues in any such analysis, including the valuation of public health care services to individuals, given that by definition there is no market and therefore no monetary price. The OECD, like most others, relies on the production cost of services as a lower bound estimate. In practice, this is likely to under-value the income equivalent value of NHS services, and hence its contribution to mitigating poverty. See OECD (2008), box 9.1 for a review of the methodological and measurement issues.

Table 1: Redistributive effects of health care based on actual use

| Inter-quintile share ratio before and after inclusion of public health expenditures based on actual use Estimates based on individual data, around 2000 | | | | | | | |
|---|--------------------|---|------------------------|--|--------------------------|---|--------------------------|
| | A. Money income | Total expenditure | | In-hospital expenditures | | Out-of-hospital expenditures | |
| | | B. Income plus health care (consumption) | C. Difference (A-B) | B1. Income plus in-hospital health care | C1. Difference (A-B1) | B2. Income plus out- of-hospital health care | C2. Difference (A-B2) |
| Denmark | 3.1 | 3.3 | -0.2 | 3.4 | -0.3 | 2.9 | 0.2 |
| Finland | 3.6 | 3.6 | 0.0 | 3.8 | -0.2 | 3.4 | 0.2 |
| Austria | 3.6 | 3.4 | 0.3 | 3.6 | 0.1 | 3.4 | 0.3 |
| Netherlands | 3.7 | 3.8 | 0.0 | 4.0 | -0.3 | 3.5 | 0.3 |
| Italy | 4.9 | 4.9 | 0.0 | 5.4 | -0.6 | 4.3 | 0.6 |
| Ireland | 4.9 | 4.7 | 0.2 | 5.0 | -0.1 | 4.5 | 0.4 |
| United Kingdom | 5.0 | 4.4 | 0.7 | 5.0 | 0.1 | 4.4 | 0.7 |
| Spain | 6.0 | 5.2 | 0.7 | 5.9 | 0.1 | 5.2 | 0.8 |
| Average | 4.3 | 4.1 | 0.2 | 4.5 | -0.2 | 3.9 | 0.4 |
| Memorandum item: | | | | | | | |
| Average for the same countries based on insurance approach | 4.3 | 3.5 | 0.8 | .. | .. | .. | .. |

Note: Countries are ranked, from first to last, in increasing order of the inter-quintile share ratio for money income.
Source: Authors' calculations based on ECHP for European countries.

1. This breakdown of health care expenditures does not correspond exactly to the one used in ECHP (e.g. OECD data provide information on public health care expenditures for medical visits, without distinguishing – for most countries – between general practitioners and specialists). Imputations of in-hospital care expenditures to an individual j (DS^H_j) are based on the number of nights spent in hospital (n_j):

$$DS^H_j = n_j \times \frac{DS^H}{N \times \sum_{i \in N} n_i}$$

where N indicates the population (i.e. those older than 15) in the sample. For expenditures outside hospital (DS^{OH}_j) the criterion used is based on the number of visits to a general practitioner (v_j), i.e.:

$$DS^{OH}_j = v_j \times \frac{(DS - DS^H)}{N \times \sum_{i \in N} v_i}$$

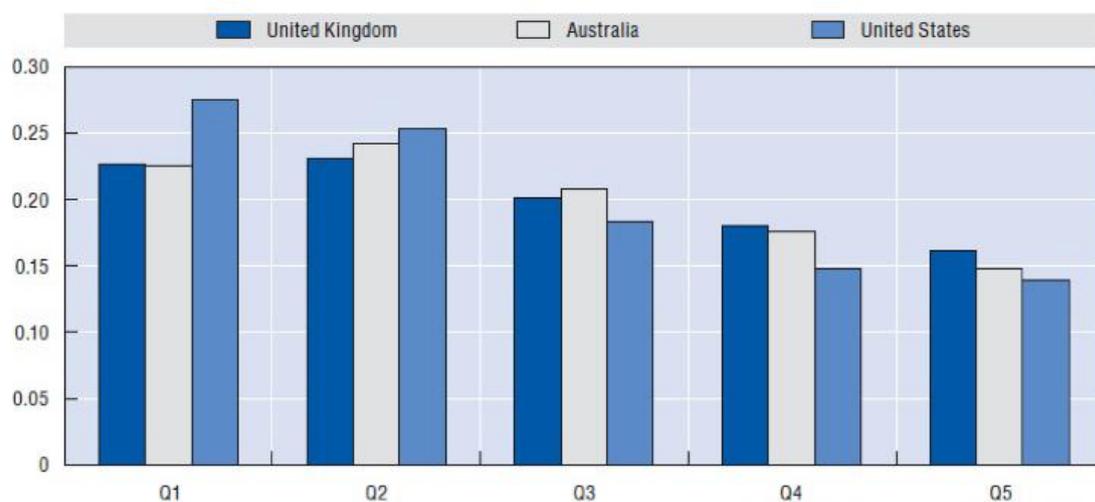
2. In the survey data used here, around 5% of the population accounted for more than 90% of the nights spent in hospital; conversely, more than 50% of the population accounted for 90% of all medical visits.

Table 1 shows for each country the starting ratio of money income between those in the highest 20 per cent of incomes versus the lowest 20 per cent. For the United Kingdom, this shows⁷⁷ the average incomes of the richest group is five times that of the poorest, a ratio second only to Spain. The effects of the redistribution of the NHS is to narrow this ratio to 4.37 – a 13 per cent narrowing of income differentials between the top and lowest 20 per cent of the population. For poorer groups the relative effect will be greater, due to their lower incomes.

⁷⁷ This information is based on actual use of services of individuals taken from surveys. Another analysis by the OECD based on the use of more aggregated groups and therefore allowing a bigger sample of countries showed a larger effect, reducing the ratio to 4.1.

More detailed comparisons with the United States and Australia (Figure 13) show that NHS universal provision results in the second income quintile receiving a slightly higher proportion of health care expenditure than the lowest 20 per cent of households in the United Kingdom, whereas in the United States it is the lowest 20 per cent who benefit most. Nonetheless, in the United Kingdom those in the lowest income quintile receive almost 25 per cent of NHS expenditure, compared to just over 15 per cent for the highest income quintile; arguably some of those in the second lowest quintile are also partially insulated from falling into the lower quintile by the benefits they receive from the NHS. Other studies confirm this general pattern for the NHS.⁷⁸

Figure 13: Distribution of public health care expenditure across income quintiles, early 2000s



StatLink  <http://dx.doi.org/10.1787/423342631545>

Note: Estimates for the United States assume that outlays for public health and hospitals are available to all individuals (i.e. they are distributed on a per capita basis) while those for Medicare and Medicaid are only available to specific segments of the population. For each country, the five bars in the chart sum to unity.

Source: Harding et al. (2004) for Australia, Lakin (2004) for the United Kingdom, and Wolff and Zacharias (2004) for the United States.

Source: http://www.oecd-ilibrary.org/social-issues-migration-health/the-impact-of-publicly-provided-services-on-the-distribution-of-resources_5k9h363c5szq-en

3.2.2 The NHS as an employer

The NHS has an important impact on poverty due to its immense size as an employer. This section reviews its role in terms of numbers employed, earnings and its wider role as a ‘good employer’, paying at least a ‘living wage’ and supporting those more at risk of poverty into work.

⁷⁸ Unpublished analysis of the General Lifestyle Survey confirms this for England, and suggests the bump in the second quintile is explained by a higher proportion of retirees on occupational pensions.

The NHS employs medical staff, but more important to poverty is its employment of non-medical staff. The best and most comprehensive data on the NHS as an employer is based on evidence submitted to the NHS Pay Review Body.⁷⁹ Table 2 shows the NHS in England employed more than 1 million non-medical staff in September 2011, the vast majority of whom were full-time.

Table 2: Non-medical staff by devolved administration and strategic health authority area, Sept 2011

| SHA Area | Headcount | Full-time equivalent |
|---------------------------------------|------------------|-----------------------------|
| North East | 65,523 | 57,055 |
| North West | 166,168 | 143,504 |
| Yorkshire and the Humber | 120,631 | 102,380 |
| East Midlands | 84,784 | 71,966 |
| West Midlands | 116,633 | 100,091 |
| East of England | 99,463 | 85,072 |
| London | 155,309 | 142,686 |
| South East Coast | 76,849 | 65,249 |
| South Central | 69,527 | 59,221 |
| South West | 108,333 | 90,257 |
| Special Health Authorities and others | 21,092 | 19,082 |
| England | 1,083,637 | 936,563 |
| Scotland | 141,203 | 119,379 |
| Wales | 78,145 | 66,005 |
| Northern Ireland | 60,984 | 49,634 |
| UK | 1,374,637 | 1,181,101 |

Sources: HSCIC; Information Services Division Scotland; StatsWales; Department of Health, Social Services and Public Safety in Northern Ireland.

Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/2159_Cm_8501_AccessibleLR_1_.pdf

The mean overall earnings for non-medical staff in the NHS in 2011 was around £25,600, with basic pay accounting for just shy of £22,500 (Figure 14). However, this varied around the country, with total earnings ranging from £16,800 to £57,000 depending on organisation. Wages and overall earnings were higher in London but also elsewhere, including parts of the north (Figure 15). The NHS is therefore a critical employer in local economies for non-medical staff, offering many full-time roles and for the average non-medical employee mean total earnings of £26,600.

⁷⁹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/2159_Cm_8501_AccessibleLR_1_.pdf

Figure 14: Estimated breakdown of average total earnings for non-medical staff in England, 2011

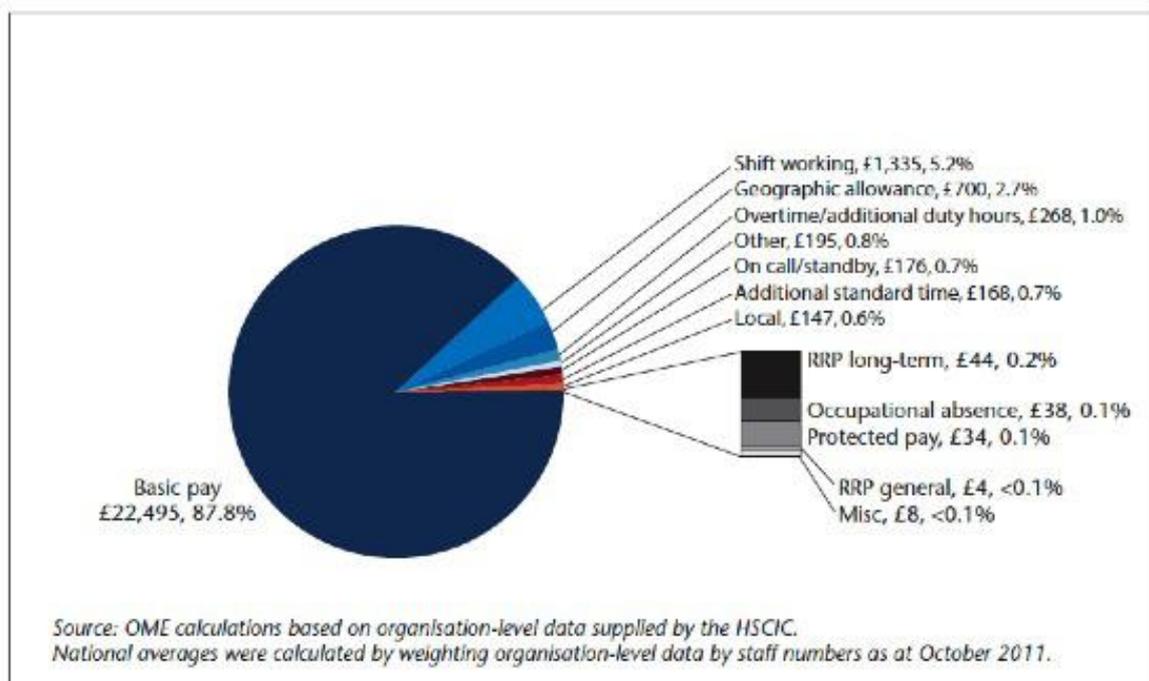
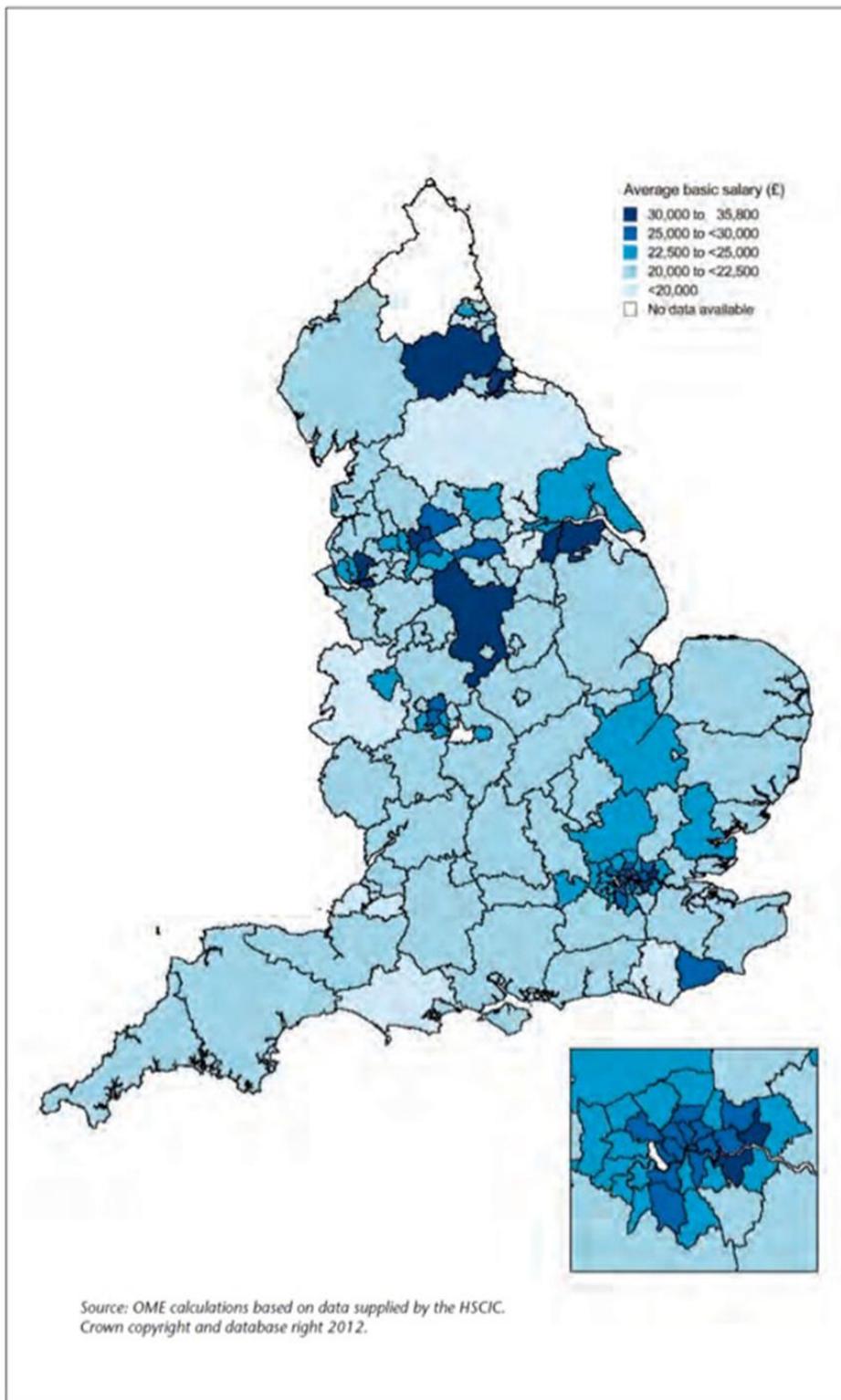


Figure 15: Mean basic salary for non-medical staff by PCT area, 2011



Source:

[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/2159 Cm 8501 AccessibleLR 1 .pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253926/2159_Cm_8501_AccessibleLR_1_.pdf)

More and more NHS organisations are showing that they are ‘good employers’. One example of this is the increasing number of NHS organisations that have signed up to paying the living wage (recent examples include the NHS in Tower Hamlets⁸⁰ and Great Ormond Street Hospital⁸¹). Other examples of accredited living wage employers⁸² include Wiltshire Ambulance Trust, Barts Health NHS trust, the Royal College of Midwives, Derbyshire Community Health Services and the Chartered Society of Physiotherapy. Unite have recently called for all NHS organisations to pay the living wage, estimating⁸³ this would cost £5 million, affecting 17,000 staff.

Finally, the NHS also has a powerful role to play in helping people into work through its own employment practice, and in helping younger people, and those who are not in employment, education or training (NEETs) into work in the first place. One example of this is Guy’s and St Thomas’ NHS Foundation Trust, through its relationship with local schools (see box).

Case study: Guy’s and St Thomas’ NHS Foundation Trust

Guy’s and St Thomas’ NHS Foundation Trust runs a range of programmes, including a ‘get into work with the NHS’ with The Prince’s Trust, which targets 16- to 24-year-old NEETs within the local community. This programme involves a three-week intensive work programme, work buddies and mentors, and aims to develop skills and experience. The trust also has 16 partnerships with local schools, taking young people on work experience. Partnerships include work with Southbank Employers’ group and their employment and referral centre Waterloo Jobshop, to deliver an employer-led recruitment programme to meet the Trust’s needs and demands, while reducing the numbers of long-term unemployed people in the local area.

Source: London Health Inequalities Network. A review of local actions in the former London Spearhead boroughs to reduce health inequalities through key social determinants: employment, housing and income. 2012 [06/03/2014]. Available from: http://www.lho.org.uk/Download/Public/17715/1/Final_LHI_Report_1.pdf.

3.2.3 The NHS as an economic entity and commissioner

Irrespective of the health care services it actually provides, the NHS is a fundamental part of national and local economies. As an economic entity in every community in England, the

⁸⁰

http://www.towerhamlets.gov.uk/news__events/news/december_2013/tower_hamlets_health_and_wellb.aspx

⁸¹ <http://www.gosh.nhs.uk/news/press-releases/2013-press-release-archive/gosh-announces-pre-christmas-pay-rise-for-lowest-paid-workers-during-london-living-wage-event/>

⁸² <http://www.livingwage.org.uk/employers>

⁸³ <http://www.unitetheunion.org/news/bullying-hunt-told-that-living-wage-should-be-implemented-in-nhs/>

sheer scale and reach of the NHS means that it has an effect on poverty, whether it realises it or not.

As a whole the NHS accounts for more than 8 per cent of GDP.⁸⁴ Recent OECD estimates also suggest that public health care services have been important in maintaining spending in the recent recession. Across countries, the average multiplier effect of public health care spending has been about 3.6 – larger than almost all other categories of spending,⁸⁵ studies of Obama’s fiscal stimulus in the United States suggest that the fiscal multiplier on Medicaid spending has been around 2.1.⁸⁶ Unfortunately, there are no national NHS specific estimates that we have been able to identify – but from these studies it is likely that the economic multiplier effect of NHS spending is somewhere in the range of two to four.

Although the NHS is important in every local economy in England, it is much more important in relative terms to some than others. Analysis of Office for National Statistics data on gross-value added (GVA)⁸⁷ by region of England gives an indication of this. The tables show the proportion of various measures of GVA contributed by ‘human, health and social work activities’, in practice the largest proportion of this will be NHS spending.⁸⁸

Table 3: Human, health and social services as a proportion of gross-valued added and poverty rate by region

| | Human, health care and social care GVA as a percentage of total GVA 2011 | | | Proportion of individuals in households below poverty rate 2007–10 |
|-----------------|--|-----------------------|---------------------|--|
| | Workplace based | Employee compensation | Residence based GVA | |
| London | 5.3% | 7.4% | 8.4% | 28.0% |
| East of England | 6.8% | 9.0% | 9.1% | 19.9% |
| South East | 9.8% | 9.1% | 8.4% | 18.1% |
| England | 7.4% | 9.9% | 9.9% | 22.6% |
| East Midlands | 8.2% | 10.4% | 9.9% | 22.3% |

⁸⁴ <http://www.kingsfund.org.uk/publications/spending-health-and-social-care-over-next-50-years>

⁸⁵ <http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf>

⁸⁶ D Wilson (2011) ‘Fiscal Spending Jobs Multipliers: Evidence from the 2009 American Recovery and Reinvestment Act,’ Federal Reserve Bank of San Francisco Working Paper 2010-17, October 2011, <http://www.frbsf.org/publications/economics/papers/2010/wp10-17bk.pdf>

⁸⁷ GVA is one indicator of economic value. It differs from GDP in that it excludes taxes and subsidies (measures for GDP are not available regionally). For more on the definition of GVA see, <http://www.ons.gov.uk/ons/guide-method/method-quality/specific/economy/regional-accounts/regional-accounts-methodology-guide.pdf>

⁸⁸ See the international definitions here, http://unstats.un.org/unsd/publication/seriesM/seriesm_4rev4e.pdf

| | | | | |
|--------------------|-------|-------|-------|-------|
| South West | 8.3% | 11.0% | 10.8% | 20.1% |
| West Midlands | 9.0% | 11.5% | 10.8% | 25.0% |
| North West | 9.1% | 12.0% | 11.9% | 23.5% |
| Yorkshire & Humber | 9.2% | 11.9% | 11.5% | 23.1% |
| North East | 10.7% | 13.8% | 15.7% | 24.3% |

Source: King’s Fund analysis of ONS data

This shows how dependent different parts of England are on NHS spending. Although measures of GVA differ, broadly speaking, London is the least dependent, with the North-East twice as dependent. Again, broadly speaking, where economic dependency on NHS spending is higher, so are poverty rates. London is an exception, despite its concentration of health care (reflected in its large number of teaching hospitals and therefore the highest absolute GVA of all regions, accounting for between 17.5 per cent and 18.8 per cent of England’s total human health and social work GVA), it is both *less* dependent than all other parts of England, due to its overall wealth *and* has the higher proportion of individuals living below the poverty threshold.

The NHS not only employs staff directly, it also commissions and procures services from third parties. It therefore indirectly affects the pay and conditions of many more workers. Low pay among contract staff in the NHS – particularly for cleaning and other support staff – was well-documented in the 2000s, such as a study⁸⁹ of low pay in NHS hospitals and other organisations in London’s East End. The impact of low pay, and its relief, was demonstrated in a later study⁹⁰ of the Royal London Hospital in Whitechapel. Many of its staff were transferred to full NHS rates, of £7.48 up from £5.25, as a result of negotiations in the move to a Private Finance Initiative deal. Fewer than half of the workers surveyed said that they had been able to afford adequate food on their previous salary; post-increase, 85 per cent were able to pay for the food their family needed. The Royal College of Physicians recently audited⁹¹ NHS trusts and found that 83 per cent (96/116) of responding trusts report that fair terms and conditions are included in the procurement conditions, while 68 per cent (79/116) say that they insist on a living wage (this is around half of all NHS hospital trusts in total).

⁸⁹ http://www.york.ac.uk/res/fbu/documents/mlpinel_sep2001.pdf

⁹⁰ <http://www.geog.qmul.ac.uk/docs/staff/58801.pdf>

⁹¹ http://www.rcplondon.ac.uk/sites/default/files/implementing_nice_web.pdf

3.2.4 Summary

In summary, in terms of the NHS's wider impact on poverty,

- The NHS plays an important – and under-recognised – role in income redistribution through benefits in kind.
- 'Human, health and social care services' – dominated by NHS spending – accounts for between 7.4 per cent and 9.9 per cent of England's GVA. It is therefore a huge contributor to all local economies. However, it is much more important in relative terms in some areas than others, from a low of 5.3 per cent to 8.4 per cent in London to a high of 10.7 per cent to 15.7 per cent in the North-East. In general, the NHS is more economically important in those parts of the country with higher levels of poverty.
- The NHS keeps people out of poverty through its direct employment (accounting for up to 15.7 per cent of employee compensation in the North-East). How it employs, and on what wages, impacts on poverty. There are positive signs that some NHS hospitals are signing up to the living wage, but systematic information is not available.
- The NHS also contracts and procures through its commissioning. There is less information on how these practices impact on poverty, although around half of NHS hospital trusts report paying the living wage.

4. The NHS reforms and their impacts on poverty

The government's reforms – to the health and care system and beyond – have important implications for the ability of the NHS to tackle poverty. This section draws on our recent assessment⁹² of the impact of the coalition's reforms in England and on wider commentary and analysis as well as the government's analysis of the distributional impact of the 2010 spending review.⁹³

4.1 The impact on NHS benefits in kind

Overall, public spending and government transfers are highly redistributive as Table 4 below shows for 2010-11.

⁹² <http://www.kingsfund.org.uk/publications/health-policy-under-coalition-government>

⁹³

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203829/Spending_Review_2010_-_distributional_impact_analysis.pdf

Table 4: Weighted average annual net equivalised household income and benefits in kind by quintile

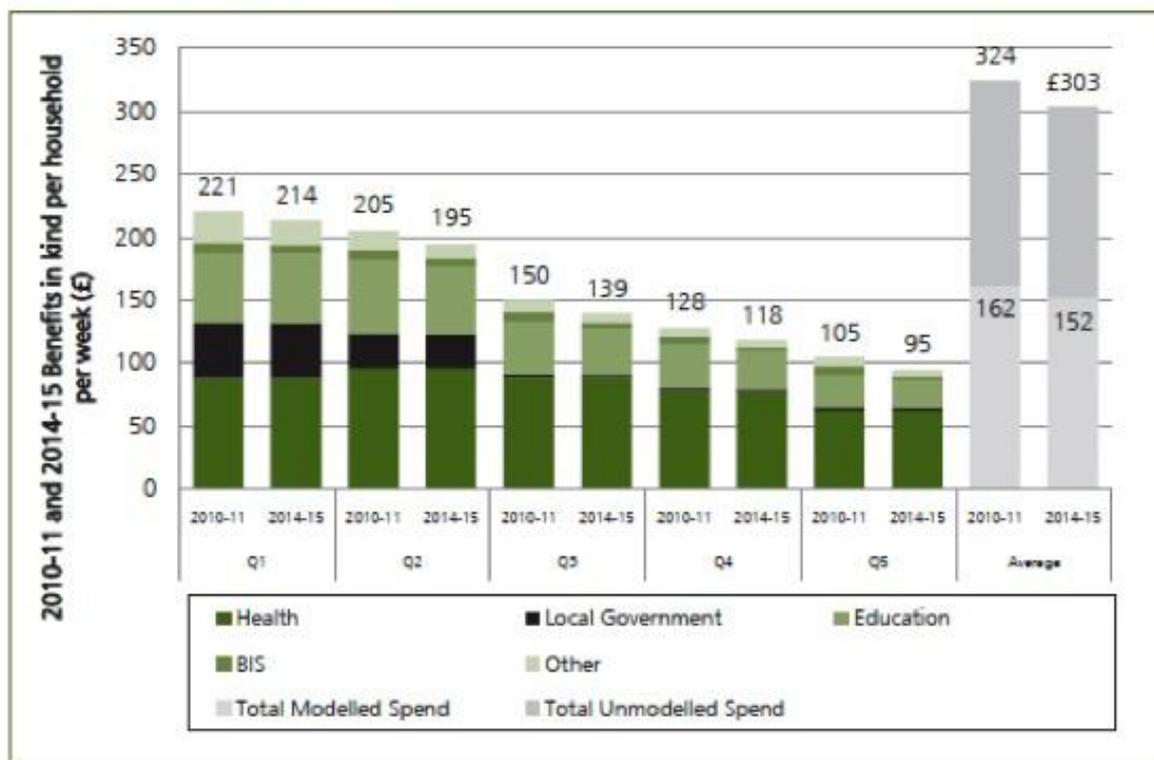
| | Q1 | Q2 | Q3 | Q4 | Q5 |
|---|---------|---------|---------|---------|---------|
| Weighted average income | £13,800 | £19,100 | £24,200 | £31,700 | £48,700 |
| Weighted average 2010-11 benefits in kind | £11,500 | £10,700 | £7,800 | £6,700 | £5,400 |

Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203829/Spending_Review_2010_-_distributional_impact_analysis.pdf

For the first time the government assessed the redistributive impact of its spending plans⁹⁴ – including on the NHS – as part of its overall plans to reduce public spending in the 2010 budget. The redistributive impact of the NHS in these figures confirms the pattern discussed in section 3.2.1, with the second income quintile benefiting most in absolute terms (Figure 16).

Figure 16: Household consumption of benefits in kind by net equivalised income quintile in 2010–11 and 2014–15 (£ per week 2010–11 prices)



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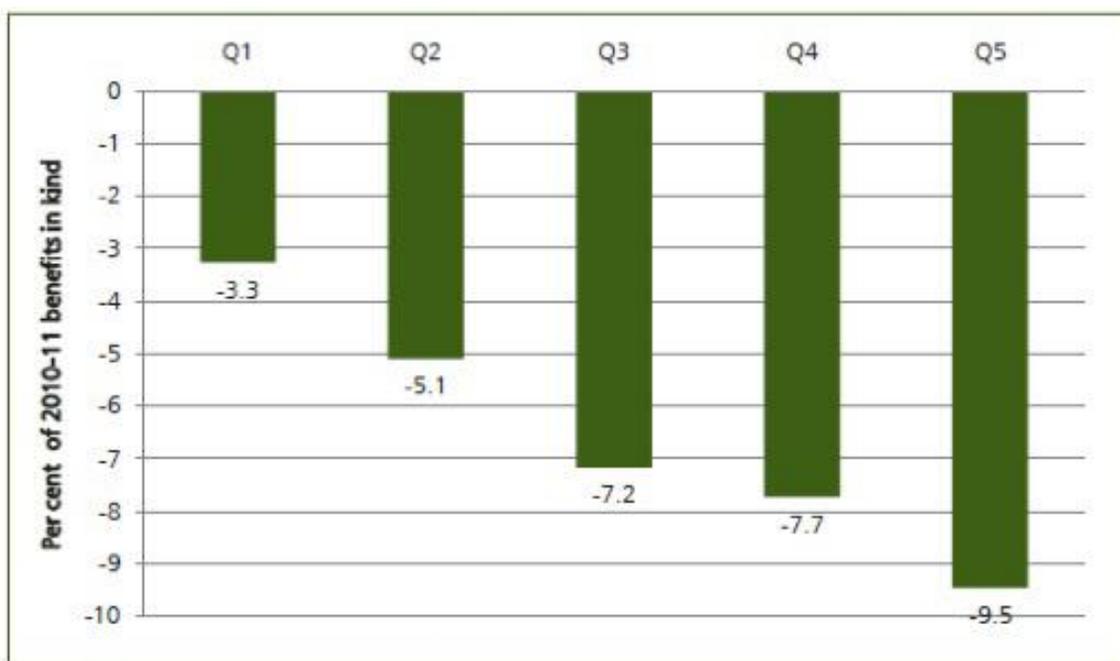
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203829/Spending_Review_2010_-_distributional_impact_analysis.pdf

Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203829/Spending_Review_2010_-_distributional_impact_analysis.pdf

The impact of the spending reforms on the NHS is broadly flat – reflecting the commitment to maintain its spending in real terms. NHS spending is increasingly important in insulating those in lower-income groups from overall reductions in government expenditure and transfers, which are reducing their incomes in real terms (Figure 17).

Figure 17: Changes in benefits in kind as a percentage of 2010–11 household consumption of benefits in kind



Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203829/Spending_Review_2010_-_distributional_impact_analysis.pdf

4.2 The NHS and wider health reforms

The core guiding policy document on the coalition’s NHS reforms, *Equity and Excellence*⁹⁵ does not mention poverty. However, there are several aspects of the NHS reforms – and the

⁹⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

consequences that have followed – that in principle *could* support a more proactive approach to poverty.

- Reforms to resource allocation. How taxpayer funds ‘get to’ different geographical parts of the NHS and, on what basis, is a critical factor in how equitable NHS services are. This includes the extent to which those areas with more people in poverty receive the greater resources they merit to adapt, mitigate, reduce and prevent poverty. Of course, simply getting ‘the right’ level of money does not mean that ‘the right’ things are done with it, but it is a pre-condition.

The coalition introduced little noticed but critical reforms to NHS resource allocation, both technically and in terms of who makes decisions. The key changes and implications are reviewed elsewhere⁹⁶ but in short the government split NHS and public health resource allocation and gave responsibility for allocating NHS resources to NHS England, not the DH – essentially taking these decisions out of the hands of the secretary of state for health for the first time. In the interim – before this change took effect – the government reduced the weight on inequalities in health in allocation decisions. On taking up its new responsibilities, NHS England has used its new-found independence to reinstate a stronger focus on allocating resources to areas with higher inequalities and unmet needs, at least in principle.⁹⁷

However, in the short term these changes will have little impact. This is because the NHS budget is essentially flat in real terms (see section 2.3) and – like secretary of states before them – NHS England has been unwilling to let any CCG see a real cut in its budgets. This overall budget constraint and the decision to protect all CCGs in real terms means that in the short term there will be very little rebalancing of funds towards ‘poorer’ places in practice, despite the important statement of principle.

- A focus on outcomes. One of the coalition’s key policy developments – across the government but with a strong initial emphasis at least in the NHS – is a stronger focus on outcomes, rather than the processes of care. The tendency to define success or failure purely in terms of the number of nurses or doctors, treatments they carry out or need to wait for, has been symptomatic in health policy, under government of all colours.

The coalition introduced a stronger focus on accountability for health care outcomes, expressed in the NHS outcomes framework⁹⁸ (and parallel frameworks in social care⁹⁹

⁹⁶ <http://www.kingsfund.org.uk/publications/improving-allocation-health-resources-england>

⁹⁷ See below for a first assessment of NHS England’s recent actions

<http://www.kingsfund.org.uk/blog/2013/12/new-ccg-allocations-straw-men-laid-rest-deeper-questions-remain>

⁹⁸ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>

⁹⁹ <https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015>

and public health¹⁰⁰). In theory, this should help re-orientate the NHS towards its ultimate purpose, and since people in poverty have poorer health, a more outcomes-focused NHS should adapt better to poverty, and indirectly help to mitigate and reduce it. Poverty features indirectly in the NHS outcomes framework, particularly in terms of employment. There are indicators both for increasing the employment of people living with LTCs, and with mental illness. In addition there is a commitment to measure inequalities across all the outcomes in the framework.¹⁰¹

- Legal duties on inequalities in health. The coalition introduced a new legal duty on health inequality reduction in the 2012 Health and Social Care Act. This is the first time that the NHS has been under such a legal obligation.¹⁰² Given the relationship between health inequality and poverty, this introduces a new lever for action on poverty in the NHS.

The duty stipulates that NHS England must, in the exercise of its functions, have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services; and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. This applies also to CCGs, and inequality reduction is stated as one of the reasons for greater integration of care. Further, and importantly, similar duties apply to the secretary of state when undertaking his or her wider duties and ‘integration’ of ‘health-related services’ is widely defined to include services related to the wider determinants of health such as housing, fuel poverty, debt, education and employment.

However, it is not clear to what extent this means that the new duties cover the reduction of inequalities in health outcomes *per se*, as opposed to access to services and outcomes from the receipt of NHS care. This has yet to be tested. In theory though, the new inequalities duties *could* be a powerful tool to drive a greater focus on poverty, as part of NHS duties on health inequalities.

- Health and wellbeing boards. In theory, the creation of health and wellbeing boards, as part of the government’s localism in health agenda, should amplify and shape the NHS’s role as part of a much broader emphasis on wellbeing. This is in the context of a widely owned view across public authorities of the health and wellbeing of communities in terms of ‘place’. Health and wellbeing boards (HWBs) are an explicit attempt to bring together all those organisations and interests – from the public, private and third sector

¹⁰⁰ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

¹⁰¹

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256458/NHS_Outcomes_Framework_equalities_analysis.pdf

¹⁰² This is additional to the general public sector equality duty that applies to all public sector organisations.

– which can have an impact on the wellbeing of local citizens. The engines of HWBs include the Joint Strategic Needs Assessment (JSNA), and the joint health and wellbeing strategy that derives from it.¹⁰³ Tackling poverty, or improving health services for those in poverty, is a legitimate goal for HWBs.

Recent analysis does suggest that HWBs are focusing on public health issues,¹⁰⁴ particularly as defined in the report *Fair Society, Healthy Lives*.¹⁰⁵ This has been highly influential in terms of high-level strategies. There is much less evidence that HWBs have been as effective at influencing the NHS in terms of its role in poverty, or in tackling wider poverty issues.¹⁰⁶

These are only some of the government's many reforms in health. Other reforms and actions are more ambiguous in their effects.

- The creation of clinical commissioning groups (CCGs). CCGs were created to give clinicians more direct control over the commissioning of health services for their populations. CCGs now directly control around £66 billion,¹⁰⁷ around 70 per cent of the NHS budget. The stated purpose of this (with the abolition of PCTs) was to give more control to those closer to patients, so that clinical services would be commissioned more appropriately. In theory, this should be good for people in poverty, but critically this depends on clinicians – particularly GPs who form the majority of CCGs – being better at commissioning through a poverty lens than PCTs. This depends on many factors including GPs' experience of and attitude to poverty and their understanding of their role. There are many instances where this is clearly the case, particularly for vulnerable groups such as homeless people (see section 6) but we argue that there is less systematic understanding or acceptance of a proactive role in poverty reduction (see section 5.2.1.2).
- NHS England as a monopoly purchaser of primary care services. A corollary of the abolition of PCTs and the creation of CCGs is that NHS England has become the monopoly purchaser of general practice provision of primary care.¹⁰⁸ In principle this gives it enormous powers of direction through contracts, and certainly influence, over

¹⁰³ See here for a discussion of the role of HWBs <http://www.kingsfund.org.uk/publications/health-and-wellbeing-boards>

¹⁰⁴ <http://www.kingsfund.org.uk/publications/health-and-wellbeing-boards-one-year-on>

¹⁰⁵ <http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review>

¹⁰⁶ For example see the link below on the extent of engagement with fuel poverty:

<http://www.ageuk.org.uk/documents/en-gb/for-professionals/health-and-wellbeing/health%20and%20wellbeing%20boards%20report.pdf?dtrk=true>

¹⁰⁷ <http://www.england.nhs.uk/allocations-2013-14/>

¹⁰⁸ This role previously lay with PCTs. With their abolition, CCGs could not be allowed to commission primary care from themselves due to obvious fears about conflicts of interest. NHS England has therefore subsumed this role.

the behaviour and practice of general practice. This means it could accelerate the adoption of good practice, for instance in adoption of known interventions that tackle health inequalities¹⁰⁹ – and therefore in terms of the adaptation at least, to poverty. In practice, this power and influence has not yet been wielded.¹¹⁰

- The abolition of most NHS targets. The government came to power pledging to ‘abolish politically motivated targets’. While many welcomed this in principle, the bonfire of targets included the end of the government’s targets on health inequalities. The merits of this have been discussed elsewhere,¹¹¹ but arguably the existence of these targets – at least in the areas of the country where they were applied – provided a focus for action among population groups that were at greatest risk of poverty, and for whom proactive health care could help them escape it. This included focused activity locally and central government funding for health inequality reductions in Spearhead¹¹² areas and local authorities. Importantly, this also included narrowing gaps in overall health inequalities in outcomes – life expectancy and infant mortality – rather than simply in access to services.
- Increasingly diverse providers. The public debate about the health reforms has mostly centred on the introduction of a more diverse supply side (often referred to as the ‘privatisation of the NHS’). The impacts of this are ambiguous. This could increasingly stimulate the involvement of third-sector organisations (such as large health and other charities with a focus on clients more likely to experience poverty) in care pathways. Where these organisations come together in a holistic manner, poverty reduction could become part of the ‘outcome set’. More diverse provision could however also fragment existing relationships and care pathways, making it harder for individual providers to see and act on poverty as part of the cause or impact of ill health.

¹⁰⁹ For instance see

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215329/dh_130949.pdf and <http://www.lho.org.uk/NHII/> and the critique of the former government’s policies on health inequalities by the National Audit Office: <http://www.nao.org.uk/report/tackling-inequalities-in-life-expectancy-in-areas-with-the-worst-health-and-deprivation/>

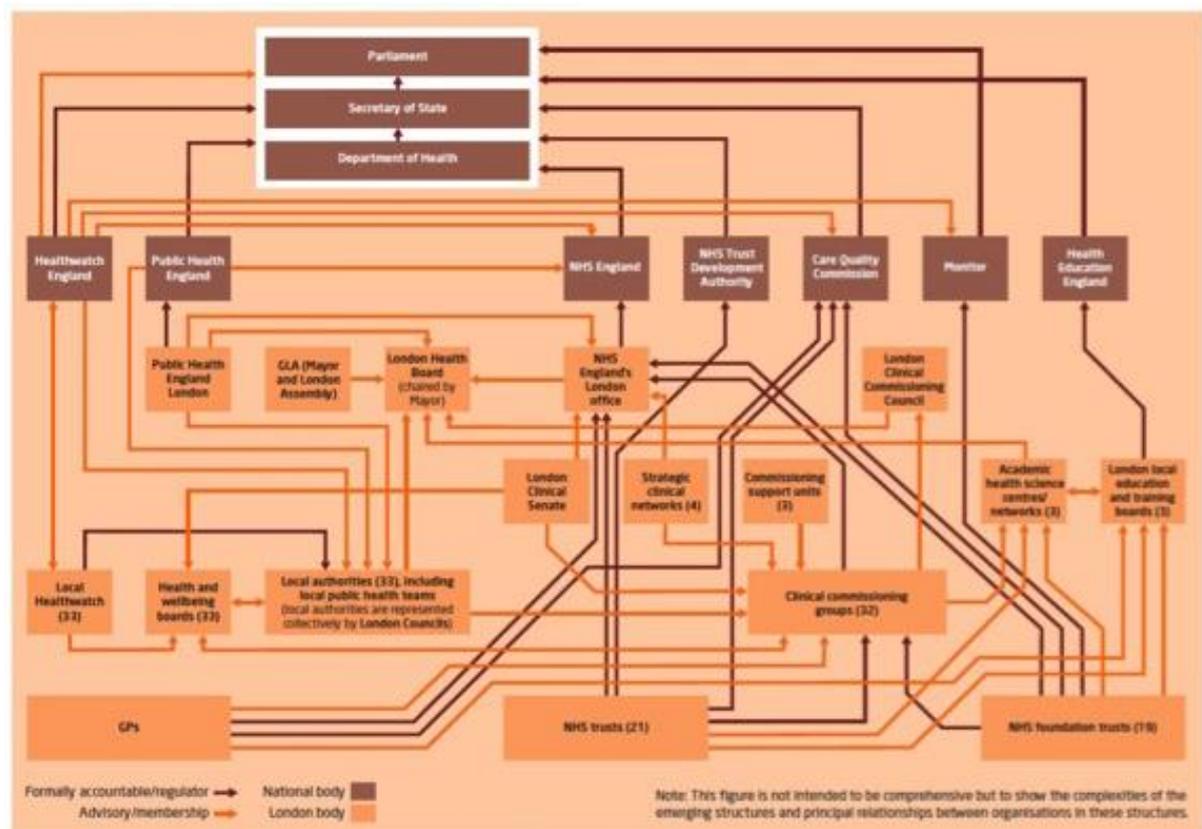
¹¹⁰ There is also some uncertainty over whether NHS England will hand some of the commissioning responsibilities for primary care to CCGs, although there are real concerns about conflicts of interest in such a move. See <http://www.gponline.com/News/article/1284000/NHS-England-confirms-plans-hand-CCGs-primary-care-commissioning-role/>

¹¹¹ See p17 <http://www.kingsfund.org.uk/publications/briefings-and-responses/consultation-response-healthy-lives-healthy-people>

¹¹² Spearheads were defined as a combination of ‘poor’ performance on life expectancy, cancer and cardiovascular disease mortality and deprivation. In practice, this boiled down to 70 Spearhead local authority areas (mapping to 62 PCTs) with a focus on urban deprived areas in London, the Midlands, North-East and North-West. Overall, 28 per cent of the population were living in Spearhead areas while the targets were in operation. For more details and a mapping of Spearhead PCTs see <http://www.nao.org.uk/wp-content/uploads/2010/07/1011186.pdf>

- Much more complex system leadership. Despite the original intentions¹¹³ of the reforms, the result has been a much more complex system, with overlapping responsibilities and organisations competing to be system leaders.¹¹⁴ This lack of clarity and complexity makes it harder to make the case, and follow through on actions that will address poverty. Therefore, regardless of views on the merits of individual health reforms, the overall impact has been to produce a more fragmented NHS with multiple overlapping commissioning routes and provision. A 'simple' version of this complexity for the London system is shown as Figure 18.

Figure 18: Principal formal relationships between health bodies in London



Source: <http://www.kingsfund.org.uk/projects/health-and-health-care-london/how-will-new-nhs-and-public-health-system-work>

¹¹³ For an analysis of why we have ended up with the system we have, and the political horse-trading that has driven it, see <http://www.kingsfund.org.uk/publications/never-again>

¹¹⁴ For example, see <http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england> and for the complexities with London as an example, see <http://www.kingsfund.org.uk/publications/leading-health-care-london>

In this myriad of relationships and accountabilities, and against a backdrop of a funding freeze, it is harder for organisations in the NHS to focus on poverty, or any other complex issues. The need for a strong central narrative is all the more important.

Beyond the health reforms per se, other government reforms have implications for the NHS and its relationship to poverty. The government has introduced a more transparent culture across government, which includes a commitment to data transparency and open access. This has great potential to ‘open the lid’ on health care and its links to poverty. NHS England is developing data linkage, both with ONS data and connecting datasets on primary care, secondary care and social care.¹¹⁵ This – subject to any legal challenge – will mean researchers and policy analysts should be able to analyse with more precision how those in poverty are treated, and how the NHS affects those in poverty.

A further area that has huge potential but has been unexplored so far in terms of its relationship with poverty, is the implications of the Social Value Act for the NHS.¹¹⁶ The legal duty for public-sector organisations to consider how the services they commission and procure improve the economic, social and environmental wellbeing of the area could be a real game changer for the NHS, shaping its procurement and commissioning in a way that would align much more closely with a poverty-focused system. There are some local examples beginning to emerge, but these are few and far between. For example, Waltham Forest re-commissioned its special educational needs transport services, with the winning contractor demonstrating how its employment of marginalised people created social value.¹¹⁷

An NHS taking social value seriously¹¹⁸ could have a transformative effect locally. Although still early days, there are some examples starting to develop including Liverpool’s Health Commission¹¹⁹ taking the lead by encouraging the NHS and others to make use of the Social Value Act. Blackburn with Darwen local authority has been working with the local NHS (formerly the PCT) on the development of a social value approach to its commissioning, as part of a broader approach to social value across the range of its responsibilities (see box).

¹¹⁵ <http://www.england.nhs.uk/2014/01/15/geraint-lewis/>

¹¹⁶ <http://www.nhsconfed.org/Publications/Documents/building-social-value.pdf>

¹¹⁷

http://www.socialenterprise.org.uk/uploads/files/2012/03/public_services_act_2012_a_brief_guide_web_version_final.pdf

¹¹⁸ See some examples in other areas of public procurement here, <http://www.jrf.org.uk/sites/files/jrf/poverty-local-governance-full.pdf>

¹¹⁹ See p10 in <http://www.liverpoolexpress.co.uk/wp-content/uploads/2014/01/Health-commission-report-low-res-for-web.pdf>

Blackburn with Darwen's approach to social value

Blackburn with Darwen has been doing three things to generate social value from its local spend.

- Developing its own local Social Value Assessment Tool and piloting it within NHS contracts.
- Analysing and maximising local public sector spend with local businesses.
- Investing in local social enterprises as part of its public services reform.

Social Value Assessment Tool: In 2012 Blackburn with Darwen Care Trust Plus (PCT) working with NHS commissioners, the local authority and the community and voluntary sector, established a group to develop and test a 'Social Value Self-Assessment Tool'. This was designed to enable providers to demonstrate the added social value they were creating. The NHS commissioning team agreed to take the responses to their Social Value Self-Assessment into account when awarding contracts. The Social Value Self-Assessment Tool asks a series of questions over 10 domains:

1. Investing in the workplace through access to high-quality occupational health
2. Increasing employability and providing high-quality employment opportunities for local people
3. Reducing congestion and promoting sustainable travel
4. Increasing prosperity and opportunity in the borough (support for businesses in Blackburn with Darwen)
5. Promoting community cohesion and diversity and equality
6. Increasing educational attainment especially in English and Maths
7. Increasing social capital through developing opportunities for volunteering
8. Increasing opportunities to aid people with learning disabilities into employment
9. Carbon Reduction
10. Rehabilitation of offenders/alcohol and substance misuse

The tool has been tested with the two of the largest local NHS trust service provider contracts for public health this year – next year they will be asked to develop an action plan to address any unutilised opportunities for local social value development identified in the assessment. In addition, the prospect of universalising use of the tools across all major local public sector contracts will be explored.

Source: For more details, please contact Dominic Harrison, Director of Public Health, Blackburn with Darwen Borough Council. Tel: 01254 666933. Email: dominic.harrison@blackburn.gov.uk

Table 5 summarises our assessment of the actual, and potential, impact of government health reforms on the ability and willingness of the NHS to tackle poverty.

Table 5: Government NHS reforms and potential effects on poverty

| Reform | Potential effect | Potential impact | Realisation to date | Details and dependencies |
|-----------------------------------|-------------------------|-------------------------|----------------------------|---|
| Resource allocation | Positive | Large | Low | In principle, NHS England has decided to focus more closely on inequalities, but given overall resource constraints on the total and the decision to insulate any individual CCG against cuts, this principle will have little effect for the foreseeable future. |
| New inequalities duties | Positive | Large | None | Depends on DH and NHS England interpretation, policing and actions |
| Outcomes frameworks | Positive | Large | None | Depends on DH and NHS England interpretation, policing and actions |
| Abolition of inequalities targets | Negative | Medium | Large | Already taken place |
| Diverse providers | Equivocal | Large | Low | Depends on the balance and focus of providers in practice (and commissioners) |
| More complex system leadership | Negative | Large | Medium | Requires strong system leadership and narrative to counteract fragmentation and confusion |
| 'Integration' policy focus | Positive | Large | Low | Little, if any, recognition of this either in government or NHS circles, or in general policy debate at present |
| HWBs | Positive | Very large | Medium | Strong representation of poverty-related issues in HWB priorities, but yet to be realised in practice. |

| | | | | |
|---|-----------|------------|------|--|
| | | | | Could be rising up agenda with media exposure on local poverty. |
| CCGs | Equivocal | Large | Low | Depends on individual CCGs, little sign of this as a live issue at present |
| NHS England as monopoly purchaser of primary care | Positive | Very large | None | Depends on whether – and how – NHS England chooses to use its monopoly power |
| Transparency and data linkage | Positive | Large | None | Depends on how users and aggregators of information use this – and whether it is used as core part of outcomes frameworks and DH judgement on whether NHS England is delivering on mandate. |
| Social Value Act | Positive | Very large | None | Great potential in terms of shaping commissioning and contracting for NHS support services. Dependent on how NHS England interprets and leads, outcome of any legal challenge to NHS on not complying. |

Navigating the thicket of the reforms towards a more poverty-aware and focused NHS is not an easy or straightforward task. Our assessment of Table 5 shows that NHS England – as the closest there is to a system leader – has an important role in developing the narrative on poverty, in taking the lead via its own actions, and in holding the local NHS to account.

There is very little history of a poverty narrative within the NHS to bring together and shape all the levers in its control, and over which it has influence, in order to deliver on poverty.

The closest the system has is a narrative on tackling inequalities. Under the last Labour government this was owned and implemented by the DH. Under the coalition government, the responsibility falls to NHS England, which under the new reforms has to assure the

secretary of state that it is delivering on the NHS Mandate's¹²⁰ commitments on inequality, and on how it is ensuring the inequalities duties are being met.

¹²⁰ The NHS Mandate contains the annual priorities and accountabilities for NHS England as defined by the secretary of state for health. See <https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

4.3 Summary

In summary,

- The coalition's focus on public spending cuts mean that the transfer of NHS benefits in kind remain an important – if widely under-recognised – tool to reduce the impact of income inequalities.
- The coalition's reforms have introduced a number of tools and levers that could, in theory, lead to a stronger poverty-aware and focused NHS. Some reforms are more ambiguous in their effects than others.
- However, in practice, there is little sign that the NHS is a more poverty-focused system now than when the government was elected in 2010.
- To some extent the system is still settling down after significant upheaval. It is undoubtedly more fragmented, which makes it harder for organisations to focus on complex issues such as poverty. But at heart, there is a lack of a coherent policy narrative from NHS England on inequalities – let alone poverty – to explain how the system's powerful levers can be used more proactively.

5. An NHS that better tackles poverty: leadership, system design and wider engagement

Our assessment of the NHS's historical and current role in tackling poverty, recent reforms and the levers and barriers, enables us to start to define what an NHS better aligned to tackling poverty would look like. This requires stronger leadership from the NHS, better system design and much wider engagement with civil society than the NHS has been used to.

We argue that 'this NHS' would be more likely to adopt at scale some of the examples of good practice outlined in section 6.

5.1 Institutional characteristics of the NHS and the mitigation, reduction and prevention of poverty

The NHS has never really been conceived by policy-makers, clinicians or others as having an explicit poverty reduction role per se. Section 2.1 sets out some of the reasons for this, flowing from the NHS's role as a universal health insurance system. But there are further institutional characteristics that inhibit the NHS from doing more for poverty, within its existing objectives.

- Management and system leadership that sees the NHS's prime role as reacting to 'expressed need' – not seeing its role as proactively discovering and treating 'unmet' need. This is reinforced by low expectations of the NHS and its equity goals being

expressed in terms of ensuring ‘equal opportunity to access health care’, rather than more proactively in terms of ‘equal access to health care outcomes’. The limits of the NHS role are seen to be in providing services equitably for ‘hard-to-reach groups’, but not in ensuring that those services are used, or that health improves as a result.

- A commissioning system where incentives, rewards and penalties remain designed for periodic bouts of illness. There is little incentive to keep people well over long periods of time, and therefore to support them in broader ways – such as poverty alleviation – that could reduce their long-term health needs. The move to ‘payment by results’ in the 2000s was designed to stimulate more activity in the NHS at a time when waiting lists for treatment were unacceptably long. The downside of the way this approach was implemented – with payment for specific episodes of care – is that it encourages compartmentalisation of the patient into separate fee-receiving conditions and treatments, and does not incentivise a whole-person approach to care over the long term.
- A provider side where the dominant ‘medical model’ of health inculcates the NHS and its training, rather than a more social model of health. The medical curriculum and training remain dominated by science-based knowledge of disease, with far less focus on the role of social conditions in the development and recovery of illness. Although there are signs of change,¹²¹ the GP has tended to be seen primarily at a policy level as the ‘gatekeeper’ to the NHS, a mechanism to ration access to expensive hospital care, rather than a guardian, custodian and partner in patients’ wider wellbeing and welfare.
- Despite the recent, welcome introduction of outcomes frameworks (see section 4.2), there remains a focus on processes and ‘treatment’, not the outcomes from that treatment. Where there are outcomes, these are narrowly defined acute medical ones, not social ones based on the long-term wellbeing and context of patients.

‘Turning the NHS’s head’ more proactively towards poverty therefore requires action across many fronts, and cannot be reduced just to issues of system design and reform. Though these are important elements, it also requires stronger system leadership and a model of health more balanced between the medical and social models. Only then will some of the examples of care in section 6 become mainstream and systematic, not isolated examples of excellence.

5.2 A system better aligned with tackling poverty

Our assessment of the potential impact of the health reforms is broadly positive – but little if anything has so far come to fruition. This is partly because of bedding down, partly due to

¹²¹ See <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/> and <http://www.kingsfund.org.uk/publications/commissioning-and-funding-general-practice>

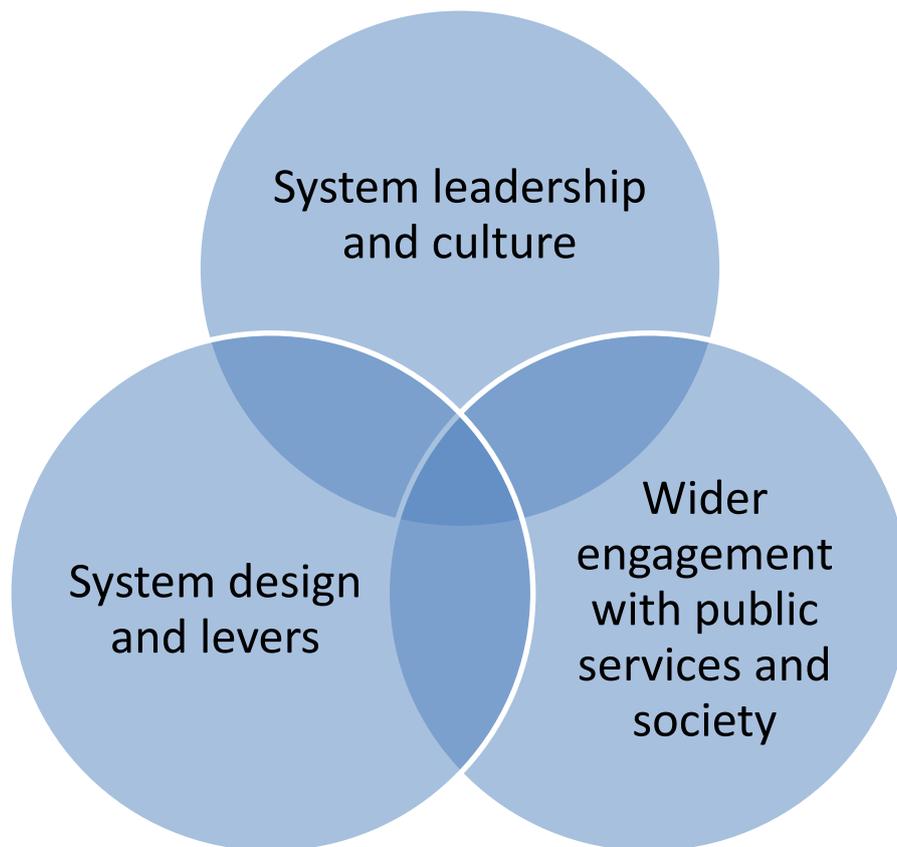
the complexity and fragmentation, and of course partly due to the wider financial context of the NHS and the rest of the public sector.

We have shown that:

- The NHS has a significant impact on poverty already – but this is little noticed, or recognised. It can therefore be easy to lose sight of how important even maintaining the status quo is to tackling poverty.
- Some of the reforms, in principle, have introduced tools and structures that should be helpful – but there has been little progress in practice.
- There is a cultural challenge and a lack of narrative and leadership which need to be overcome.

The challenge then is to rise above the current circumstances and to make improvements on three broad fronts (Figure 19). There are technical elements in the system that could be better aligned to action on poverty, but these will not be ‘pulled’ into place unless there is better system leadership and a narrative on poverty from NHS England and from clinicians and their leaders themselves. To maximise impact, the NHS needs to be more engaged with other public services and society as a whole. To support this, there needs to be a much wider awareness of how the NHS *already* tackles poverty.

Figure 19: A poverty-focused NHS



5.2.1 System leadership and culture

System leadership and different cultural attitudes to poverty – and what the NHS can and should do about it – are necessary conditions for improvement. These underpin more technical changes to system design and levers, and help prepare the NHS for wider engagement on poverty. The two critical players in this are NHS England and the medical profession.

5.2.1.1 NHS England

NHS England has said little, if anything, directly about poverty. Its concerns are primarily with equality and inequality – for historical reasons bound up with the creation of the NHS and specific legislation. While it carries that history with it, NHS England is a new organisation that has been slow off the mark in explaining its vision and the importance of inequality reduction in its goals and expectations, of itself and of the wider NHS. This is despite some positive early rhetoric about inequalities being at the centre of its approach to policy and some specific actions.

Only in December 2013 did it have its first major board-level discussion of its strategic approach to equalities and inequalities.¹²² The paper has been challenged elsewhere¹²³ particularly for the lack of recognition of the wider financial and policy context. Despite this, it does include some potentially important commitments including: incentivising and prioritising improvements in primary care towards groups and people, including homeless people, with the worst health outcomes; and embedding tackling inequalities in the CCG assurance and support regimes.

Each of the commitments can be interpreted and implemented in different ways. Potentially, these could be very strong levers for tackling inequalities in health – and by extension poverty – but the proof of the pudding will be in the eating. The challenge above is important – if NHS England does not ‘see and promote’ poverty as one of the root causes of the health inequalities it seeks to tackle, it is less likely that the NHS will either.

5.2.1.2 Clinical leadership

The consequence of Michael Marmot’s tenure as President of the BMA has raised the issue of inequalities in health within the medical profession. Furthermore, it has led the leaders of 19 workforce organisations across the range of health and allied professions to commit to specific actions outlined in *Working for Health Equity: The role of health professionals*.¹²⁴

The foreword to the report is worth repeating.

Doctors are involved in treating illness but most accept they have an important role in prevention. If illness arises from the conditions in which people are born, grow, live, work, and age – the social determinants of health – should the doctors not get involved in the causes of illness and, indeed, the causes of the cause? The BMA picked up the challenge and produced a report on what doctors could do about the social determinants of health. But why stop at doctors? Other health professionals have key roles to play on improving the conditions of people’s lives and hence could have profound effects on health inequalities. This report builds on the BMA’s report and the inspiring work of health professionals.

The report sets out recommendations in six core areas (Table 6) and sets out many specific commitments by clinical workforce organisations.¹²⁵ We refer to several case studies¹²⁶ of practice in section 6.

¹²² <http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-1.pdf>

¹²³ <http://localdemocracyandhealth.com/2014/01/06/at-last-nhs-england-report-on-health-inequalities-but-is-it-any-good/#comment-3678>

¹²⁴ <http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals>

¹²⁵ <http://www.instituteofhealthequity.org/Content/FileManager/healthprofs/all-commitments-by-theme.pdf>

¹²⁶ <http://www.instituteofhealthequity.org/Content/FileManager/healthprofs/case-study-document.pdf>

Table 6: Marmot recommendations for the role of health professionals¹²⁷

| Marmot themes | Recommendations |
|--|---|
| Workforce education and training | <ul style="list-style-type: none"> ❖ Social determinants of health (SDH) and health professionals' role in tackling inequalities in health should be included as mandatory, assessed elements of under- and post-graduate education ❖ Social skills and specifics, including for example, taking social history of patients and referral to non-medical services should be embedded as above ❖ Student placements in deprived areas, a core part of every course ❖ SDH mandatory part of continuing professional development (CPD) ❖ Universities to provide greater access to medical careers from students from all socio-economic backgrounds |
| Working with individuals and communities | <ul style="list-style-type: none"> ❖ Build relationships of trust with patients and wider communities ❖ Take social histories of patients to enable best care, onward referral to non-medical agencies for root cause, aggregate data to feed into planning |
| NHS organisations (as managers) | <ul style="list-style-type: none"> ❖ Staff have good-quality work – with control, respect, reward and occupational health services ❖ The purchasing power of the NHS is used to the benefit of the local population, including focused employment strategies ❖ Strategies on health inequalities are at the core of organisational policies |
| Working in partnership | <ul style="list-style-type: none"> ❖ Partnerships within the health sector across disciplinary boundaries |

¹²⁷ King's Fund summary of <http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals>

| | |
|--|--|
| | <ul style="list-style-type: none"> ❖ Integrate with other public-sector organisations to reduce inequalities, in line with the new inequalities duties, and assess for impact ❖ Health professionals on CCGs should tackle inequality as advocates, commissioners, employers and in their provider roles |
| Workforce as advocates | <ul style="list-style-type: none"> ❖ Health professionals should be advocates for patients and their communities where they see wider determinants impacting detrimentally on patients' lives ❖ They should also advocate for changes to medical education and practice and for national policy change |
| The health system – challenges and opportunities | <ul style="list-style-type: none"> ❖ Health professionals should use the new opportunities in the reforms including the new legal duties on inequalities |

Many of these resonate with our assessment and analysis above. But, more specifically Marmot makes strong and important recommendations for workforce education and training, strengthening and mandating the role of the social determinants of health in clinical education and training.

There have been previous efforts to include a wider perspective in medical training¹²⁸ but their effectiveness has been questioned.¹²⁹ Recent changes to the training of GPs could potentially support a more inequalities-focused approach – their training has been lengthened from three to four years and the Royal College of General Practitioners' enhanced and extended training bid highlights the need for GPs to be involved in community leadership, public health and leading integrated teams as a means to reduce health inequalities.¹³⁰

But there needs to be a recognition that this does not come naturally for many GPs or other health professionals, and it is not just about training the next generation. In their assessment of how general practice needs to move beyond the surgery door, the Nuffield Trust argues¹³¹ that,

¹²⁸ <http://jpubhealth.oxfordjournals.org/content/32/1/125.full.pdf>

¹²⁹ <http://intl-jpubhealth.oxfordjournals.org/content/32/1/132.full>

¹³⁰ See http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z-policy/Case_for_enhanced_GP_training.ashx

¹³¹ <http://www.nuffieldtrust.org.uk/publications/reclaiming-population-health-perspective>

The first challenge facing those eager to build a population health approach within general practice is to articulate a vision that can inspire and motivate primary care professionals. Many of those interviewed felt that many of their colleagues believe there is little scope to deliver more than reactive care...

But they also offer examples of where this has happened including in Cumbria¹³² and in Scotland where work has been ongoing through the Deep End Project to support the 100 most deprived general practices in Scotland.¹³³ The prime issue for Deep End GPs in doing more for disadvantaged patients was a shortage of time, followed by problems including lack of mental health support, and the need for more support for social prescribing (see box).

¹³² http://www.radcliffehealth.com/sites/radcliffehealth.com/files/ljpc_articles/4_2_3.pdf

¹³³

http://www.gcph.co.uk/assets/0000/2586/FINAL_VERSION_for_publication_without_financial_statement.pdf

Case study: 'GPs at the Deep End', Glasgow

'GPs at the Deep End' was devised by academic and community GPs and works in the 100 most deprived areas in Scotland. The project acknowledges that while the ability of health care to change the social conditions that lead to ill health is limited, health care is nonetheless a social determinant and doctors are part of the social capital of communities. Practices that provide jobs, camaraderie and hope are contributors to the health of communities and to the people who live in those communities.

Six interrelated recommendations in the report (see link below) set out to reverse the 'inverse care' law in Scotland through a package of measures. They are as follows:

1. Additional time for consultations with patients, including targeted appointments for the neediest patients.
2. Support for serial encounters and the productive use of long-term relationships.
3. Attachment of staff from area-based services (social work, mental health, addictions, child health) to general practices or groups of practices.
4. Development of a lay link worker role connecting practices and patients with community resources for health.
5. Support for training and leadership development within and between practices, and linked to locality planning. Including protected time for practices to share experience, information, learning and activity on a cluster basis, following the examples of the Primary Care Collaborative and Links Project. This should also encompass evaluation and research based on and informing the person-centred work of general practice, especially in very deprived areas.
6. A new partnership between leadership at the top and bottom of the NHS, based on mutual understanding, accountability and respect. This requires a greater focus by all central NHS agencies on supporting general practices that serve very deprived areas, beginning with an audit of what these agencies currently do in very deprived areas.

Further information on 'GPs at the Deep End' can be found at

http://www.gla.ac.uk/media/media_271030_en.pdf

In England, recent policy¹³⁴ has freed up restrictions on GPs' time, allowing more flexibility in appointment times. The intention is to allow GPs to offer more time to those with complex medical conditions. This more flexible approach could be used – with leadership and capability – to allow GPs to offer more time to those with complex social conditions,

¹³⁴ <https://www.gov.uk/government/news/personalised-gp-care-will-bring-back-old-fashioned-family-doctors>

and to allow them to co-produce poverty-reducing outcomes as well as health-enhancing ones.

5.2.1.3 Wider leadership

While NHS England and the health professions are the most important actors, others also need to take a leading role. This includes bodies with specific interests in promoting good health outcomes for patients with long-term conditions through more integrated services. This group of patients are the major challenge to the future sustainability of the NHS.¹³⁵ We now have convincing evidence of how socio-economic factors skew the demand and need for these services, yet this has not been translated into models of care. Institutions with leadership positions such as NHS England, Public Health England and the Department of Health need to be clearer about this reality and help the NHS work through the implications for service design, so that people with lower incomes and in poverty receive adequate services and stay in the workforce longer, insulating them from the risks of poverty. Others with influence have a similar responsibility.

5.2.2 System design and levers

We have reviewed the main system levers in play for poverty in section 3.2 and 4.2, so will not do so in detail again here. Each of these levers can be tweaked or pulled in various ways to increase the incentives for the NHS to recognise and tackle poverty, beyond simply adapting to it. How each of these is pulled, in what combination and to what extent is not something that can be dictated. However, one vignette of a more poverty-aligned system is the following.

- An NHS that understands how much of its funding is delivered for the consequences of poverty and is more strongly held to account¹³⁶ for doing so, through indicators in the outcomes frameworks, the NHS Mandate and other mechanisms.
- An NHS that understands and recognises its role in reducing income inequalities, helping people stay in good-quality work (both directly and through its commissioning); demonstrates the social value of its commissioning and actions; and pays the living wage by default.
- An NHS which is clear on what the new inequalities duties mean – how they relate to poverty reduction – and how it will be held to account for meeting them.
- An NHS that (with other local and national partners such as PHE, HWBs, NHSE and the LGA) leads a local debate about its role in mitigating, reducing and preventing poverty.

¹³⁵ See <http://www.kingsfund.org.uk/publications/transforming-delivery-health-and-social-care>

¹³⁶ For more on accountability for spending resources in alignment with why they were allocated, see <http://www.kingsfund.org.uk/publications/improving-allocation-health-resources-england>

- A medical community that lives the recommendations of Working for Health Equity – particularly in respect to medical education and training – and a better balance between the medical and social models of health.
- An NHS that is a full partner around the HWB table and presses for poverty measures in strategy development, and recognises that in any given community it is likely to be the biggest part of the solution – because of its economic size, as much as the delivery of its services.
- An NHS where primary care is proactive, and sees its role as changing the wider determinants of health, not just reacting to illness and promoting behaviour change.
- An NHS that first recognises and then is successful at supporting those in child poverty; with mental health problems; and in integrating care for patients with LTCs and recognises the critical importance of people’s socio-economic position – including poverty – in that integration, and in the prevention of LTCs.

5.2.3 Wider engagement with public services and civil society

Stronger leadership, cultural change and more aligned system levers are two-thirds of the solution. The final piece of the jigsaw is wider engagement by the NHS with other public services and civil society.

Health and wellbeing boards support this to some degree, but there is a danger that the complexity of the JSNA process led by experts could disenfranchise citizens and end-users. Gamsu¹³⁷ suggests that ‘Fairness Commissions’ could be a way to complement this technical process. Fairness commissions are in the spirit of the Localism Act, which gives local authorities the permission to act much more innovatively to fulfil their responsibilities, and to work more closely with their communities.

There are several examples of fairness or related commissions, including in York, Wakefield, Islington and Sheffield. Gamsu argues that these are characterised by the following.

- A recognition from the outset of a key strategic challenge – a ‘wicked issue’ – that needs addressing. By going public on the issue, local leaders expose themselves to debate about whether they have chosen the right area and are able to engage local press and the public about why they have prioritised this.
- Engagement of leaders and communities from the beginning – commissions are able to engage a much wider group of stakeholders than HWBs.

¹³⁷ <http://localdemocracyandhealth.com/2012/05/21/local-commissions-tackle-social-determinants-of-health/>

- Being time-limited and quick.
- The problem of health inequalities is located in a wider determinants agenda. Many of these commissions do not set out to reduce health inequalities as the core objective – they are built around a broader notion of fairness and equity. By tackling these wider issues – including poverty – in the power of local authorities and their communities, health inequalities will be addressed. There is therefore a potential for win-wins, for poverty and for health inequalities goals.

These commissions can be viewed as a form of alignment mechanism, and can be seen as a ‘way in’ for the local NHS to act jointly with others on poverty while simultaneously tackling its health inequality and other objectives, such as integration.

As one example, Liverpool’s Health Commission has just reported.¹³⁸ There, the NHS is a core partner in an inclusive and integrated approach to health and wellbeing shared across the city (see box). This goes far beyond a vision for integrated health and care services – though this is part of the solution. Instead it draws together many of the strands outlined above into a neighbourhood-based model of care provision uniting all relevant health, social care and other resources in a single unifying strategic plan based on the Joint Strategic Needs Assessment (JSNA).¹³⁹ At the heart of this is a preventive approach, bringing multiple services – such as housing, benefits, Citizens Advice, and debt management – to common neighbourhood sites and the development of the NHS as a hub for work, including apprenticeships and local back-to-work schemes that target people from disadvantaged communities.

¹³⁸ <http://www.liverpoolexpress.co.uk/wp-content/uploads/2014/01/Health-commission-report-low-res-for-web.pdf>

¹³⁹ JSNAs are assessments of the current and future health and social care needs of local communities and are the basis for planning local services. The JSNA is a statutory duty of health and wellbeing boards. See <https://www.gov.uk/government/publications/jsnas-and-jhws-statutory-guidance>

Case study: Liverpool's Fairness and Health Commissions

The problem

As a city, Liverpool has made major achievements in the last 20 years in urban and economic regeneration. It has exceeded public health targets and narrowed some measures of health inequalities: and it has been left a strong primary care legacy by the PCT. However, the city also has particular challenges. Despite the success of its public health programmes, it remains at the bottom of the league for most indices of deprivation, and many of its citizens have a history of poverty, unemployment and social exclusion.

While inequalities in life expectancy between Liverpool and England are decreasing, there remains a significant gap. One in three Liverpool children live in poverty compared with one in five children in England. Levels of unemployment in the city are well above the national average, with 22 per cent of working-age adults claiming unemployment benefit compared to 12.5 per cent for Great Britain. Liverpool has the second lowest average household income of the eight core cities.

Background to the Liverpool Fairness Commission and the Liverpool Health Commission

The Liverpool Fairness Commission was established by Liverpool City Council with support and funding from the University of Liverpool. Its mission is to consider how to build a fairer future in light of the current austerity measures. The commission put forward a challenge for the public and private sectors and civic leaders to come together to consider a blueprint for lasting fairness and a better quality of life for all. As part of the overall commission, the city's mayor invited Professor Sir Ian Gilmore to lead a commission to determine how best to support and improve the health and wellbeing of the people of Liverpool. After a year of consultation and analysis, the commission set out a number of conclusions and recommendations for the Liverpool health care system.

Recommendations

The commission concluded that minor modifications in the existing health care system would not be enough to meet the challenges that Liverpool faces. Instead it recommended that the health care system focus much more on tackling the social determinants of health. It also highlighted that this focus requires all key partners in the region (including the NHS, the local authority, the Academic Health Science Network, the voluntary sector etc) to work together to transform the health outcomes of the people of Liverpool. Furthermore, the commission called for full engagement with society and wider public services to affect health and wellbeing traditionally outside the remit of the NHS.

The Liverpool model is an example where the NHS is brought into tackling the structural causes and consequences of poverty as a key stakeholder in a city-wide strategy. While it

is too early to judge the effects, such commissions have potential in raising the awareness and commitment of NHS leaders to change the conditions which determine poverty.

See <http://liverpoolfairnesscommission.com/report.php> and <http://liverpool.gov.uk/media/770697/healthcommissionerport2.pdf>

As well as the Localism Act, HWBs and fairness commissions, community budgeting and resource allocation also have a role to play. The JRF has recently reviewed the use of community budgeting as part of wider work looking at addressing poverty through place-based policies and governance.¹⁴⁰ The obvious place to start in terms of community budgeting in relation to the NHS is health and social care integration (now boosted by the £3.8 billion Better Care Fund).¹⁴¹ But this should not be the limit of ambition. The National Audit Office¹⁴² thought it too early to judge the effectiveness of community budgeting, but the work for the JRF shows that the NHS is involved in some of the specific examples including for troubled families and homeless people. However, as the NHS is often the largest single employer and economic entity in many local authorities, it should be at the core of most, if not all, approaches to community budgeting at scale. There is little evidence of this level of commitment and engagement as yet.

Beyond community budgeting is the prospect of more unified health and wider public service resource allocations from government. Theoretically, closer alignment of resource allocation *across public services* (as opposed to a greater focus on inequality weighting within the health formula) would make it much easier for local areas to align their services around the holistic needs of people within their communities. It makes sense to look much more closely¹⁴³ at how NHS resource allocation decisions dovetail – or not – with other public service allocations that contribute to health and wellbeing. Calls to align or bring together allocations for local areas will only intensify as discretionary local public services face shrinking (or at best stagnant) budgets for the foreseeable future.

The National Audit Office and Public Accounts Committee have recently reviewed¹⁴⁴ how more than £150 billion of government spending (including education, police, fire and other services as well as health) is allocated to local bodies. They found scant evidence that departments were considering how their individual approaches to allocations contributed to equitable public sector funding allocation in local areas as a whole. Without urgent work to align how budgets are defined across public services, the shared pools of resource available will be increasingly out of sync with the shared needs to be met. As a minimum, NHS

¹⁴⁰ <http://www.jrf.org.uk/sites/files/jrf/poverty-local-governance-full.pdf>

¹⁴¹ <http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund>

¹⁴² http://www.nao.org.uk/wp-content/uploads/2013/03/10088-002_Whole-Place-Community-Budgets.pdf

¹⁴³ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-allocation-of-health-resources-in-england-kingsfund-apr13.pdf

¹⁴⁴ www.publications.parliament.uk/pa/cm201012/cmselect/cmpublic/1502/1502.pdf

England should align its periodic reviews of health allocation approaches as closely as possible with those of other government departments.

A more radical approach would be a single allocation process that devolved all public sector resources down to local areas. Within that, there are many models that could be considered, from a wider roll-out of community budget pilots to Labour's 'possible'¹⁴⁵ single budget vision – and the call from the largest cities outside London for an extension to whole place budgets (Johnstone 2013).

5.2.4 Summary

In summary

- The NHS has some institutional characteristics that 'get in the way of' tackling poverty. These include an imbalance towards medical rather than social models of health, a focus on processes of care rather than on outcomes for health and wellbeing, and payment systems that incentivise viewing the patient as a series of conditions and diseases, rather than as an individual living within a broader social context.
- A more poverty-aware and focused NHS requires stronger leadership, better aligned system design, and stronger engagement with other public services and civic society.
- This means
 - stronger leadership from NHS England, especially in setting out its expectations and narrative on poverty, and from clinicians (it is heartening to see so many clinical bodies sign up to *Working for Health Equity: The role of health professionals*, but we now need to see action)
 - a more poverty-aligned system including an NHS that is aware of its existing impact on poverty; clear what the new inequalities duties mean and how they relate to poverty reduction; where primary care is proactive and sees its role as changing the wider determinants of health as well as reacting to illness; and is expected to, rewarded and accountable for doing better for people with mental health problems, LTCs and child poverty
 - an NHS playing a leading role locally, for example in 'fairness' and related commissions, bringing its huge economic power into play more positively for poverty, by paying the living wage by default rather than by exception and

¹⁴⁵ There is still ongoing debate about the possibilities of single budgets. For instance, the recent 'Oldham Report' prepared for Labour on the care for people with LTCs, did not recommend this directly. http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf

commissioning for social value. Beyond this, the NHS's role will be a critical force in the next few years as financial pressures and policy move towards closer alignment of public resources and budgets locally.

6 What a more poverty-focused NHS would be doing more of: case studies

Given the interconnected nature between poverty and health, the health system as a whole has the potential to have a much greater impact in tackling poverty than it currently does. However, as we have set out earlier, those people working in the NHS are often unaware of its impact – and where they are, they tend to think of their role as primarily reactive, adapting to poverty, rather than in terms of mitigating, preventing or reducing it.

But throughout this policy discussion, we have referred to examples where the NHS is already doing this well. This section focuses on further case studies and examples primarily in service delivery. There is less evidence of where it is *knowingly* using its economic power, employment and commissioning to tackle poverty, although some areas, such as Blackburn with Darwen, are using the Social Value Act creatively for this purpose (see box).

6.1 Case studies of adaptation, mitigation, reduction and prevention of poverty

The box on page 9 sets out how the NHS can tackle poverty in many ways. Figure 20 collates details of 20 case studies where the NHS is involved in tackling poverty across this schema.

Figure 20: Case studies of NHS good practice in adapting, mitigating, reducing and preventing poverty

- Derbyshire's NHS commissioners have worked with Derbyshire Citizen's Advice Bureau since 1995 to provide welfare advice in GP surgeries (see Annex 1, s). It now covers 98 of the 102 practices in the county with a 3-hour advice session per week in each practice, staffed by paid members of staff (see box). The project puts free advice at the heart of a largely rural community; it gives GPs and practice staff another referral option to a service based within their own practice. The service is currently funded by Derbyshire Council as part of its public health role.

Case study: Derbyshire GPs and the Citizens Advice Bureau – welfare rights and support in a general practice setting

The problem

Economic social welfare plays a critical role in protecting and improving the health and wellbeing of individuals and communities. However around one in three eligible individuals do not claim (including disproportionately vulnerable groups), creating demand on local services (for example, one in seven GP consultations involve social welfare issues). A significant proportion of entitlements go unclaimed, (an estimated 30 per cent for primary benefits) including – disproportionately – health-related entitlements for vulnerable groups, such as older people. Failure to claim entitlements is associated with factors such as system complexity, lack of knowledge and difficulty in making claims. Welfare advice services in GP surgeries increase benefits uptake. They are a practical way of reaching those in poverty to help them to resolve the social and financial issues which likely impair their health (both mental and physical) and wellbeing.

The model/the role of the NHS

A local PCT in Derbyshire commissioned the CAB to provide a limited advice service in a couple of GP surgeries in 1995. After a slow start the service proved to be popular with patients and GPs. It was progressively scaled up and now covers 98 out of 102 practices in the county, with a weekly 3-hour advice session in each practice, staffed by paid members of staff. It is currently funded by Derbyshire Council Public Health. The project puts free advice at the heart of a largely rural community; it gives GPs and practice staff another referral option to a service based within their own practice.

Dr Gale at Somercoates medical practice says,

When a patient comes to me and says that they are depressed and then tells me of all the problems they have, not enough money for food, heat and rent, what is the use trying to treat them? I would be surprised if they were not depressed. They need their problems resolving first. That is why having the CAB in the surgery is so useful.

The main involvement of the NHS is use of space within the GP practice. However its success rests upon the co-operation of GPs and practice staff.

Cost implications and outcomes in Derbyshire (2012/13)

- Clients advised = 6,226
- Problems dealt with = 30,528
- Additional income for clients = £9,024,744
- Debt managed = £6,095,434
- Cost = £767,377

- Cost per client = £123
- Overall cost per annum = £800,000 (approx.)

Impact on patients and poverty

The service is highly popular with patients and GPs. Users of the service can see an adviser without the stigma of having to attend an advice centre. The need for this programme has intensified since the economic downturn began in 2007/8. Demand for advice in all settings is increasing. Many of the users of the service would not use it at main locations, so the reach is extended.

Concluding remarks

The model of care in Derbyshire is an excellent example of an external organisation (the Citizens Advice Bureau) contracting with the NHS to reduce/mitigate the impact of those in poverty via primary care settings. The model is a relatively easy and flexible model to scale across different localities. The main determinant of scalability is funding. In Derbyshire this has required leadership from three main partners, the local authority (previously the PCT), the NHS (in the form of the GPs) and the external organisation. In Derbyshire we see that leadership from the council's public health team and GPs, along with wider engagement with other public services has enabled the service to adapt to the needs of the most vulnerable children in the area.

See: <http://www.healthyadvice.org.uk/>

- For the most vulnerable groups, services often need to be tailored and specific. This is true for homeless patients in many cases.
 - Great Chapel Street (see Annex 1, e) is a walk-in medical centre for homeless people which aims to reduce social exclusion and reduce inequalities in health.
 - Inclusion Healthcare (see Annex 1, g) is a social enterprise which specialises in providing health services to homeless people and other highly vulnerable groups. It also works with partners to provide housing advice and referral and tenancy support.
 - Homerton Hospital Housing Service (see Annex 1, f) works with the local homeless persons unit to provide rapid housing for tuberculosis (TB) patients at risk of homelessness. Without this, they are at risk of non-completion of a six-month treatment period.

- The NHS – in some places – is starting to develop a more social model of health.
 - Leeds School of Medicine (see Annex 1, n) has refocused its teaching and training on the social determinants of health, helping shape the knowledge and culture of future doctors.
 - The Ontario College of Family Physicians (see Annex 1, p) has developed tools for its doctors to help identify and adjust treatment for people in poverty in primary care and to refer on where appropriate to relevant welfare agencies.
 - The Bromley-by-Bow medical centre¹⁴⁶ in London’s East End (see Annex 1, k) has long been held up as a model for the NHS in England in terms of delivering services to a highly disadvantaged population with a wide range of problems related to poverty. It takes a holistic view of health, and its medical centre acts as a hub for wider services including employment programmes, benefits and housing advice. In Glasgow, many GP practices have come together to tackle disadvantage among their patients (see Annex 1, t).
 - Guy’s and St Thomas’ Foundation Trust (see Annex 1, u) runs a range of programmes including a ‘get into work with the NHS’ with The Prince’s Trust that targets young NEETs. It also has partnerships with 16 local schools, taking young people on work experience.

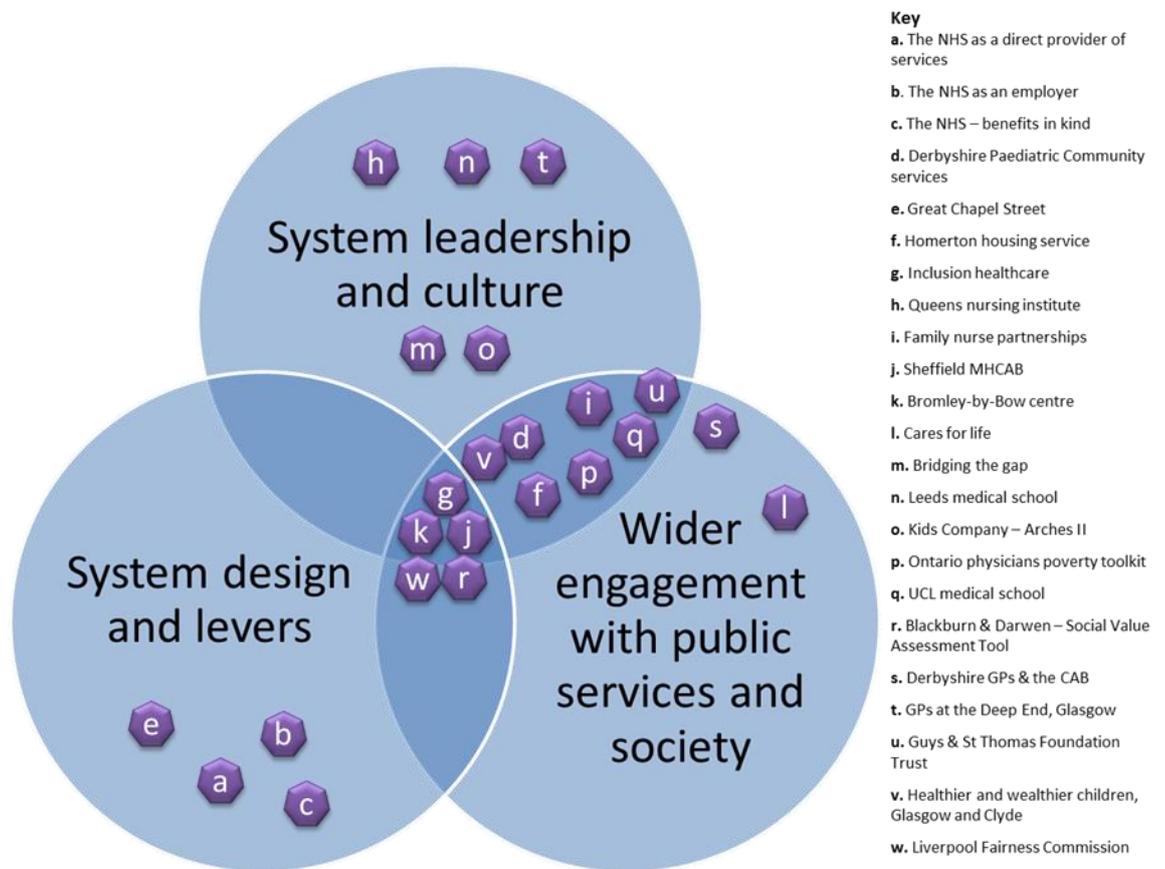
But the overall message from these and the other case studies set out in Annex 1 is that there is no silver bullet. Each local area will require a combination of approaches, adapted to local needs and local assets to fit their own circumstances.

6.2 Moving beyond islands of good practice

We argued in section 5.2 that leadership, system design and greater engagement with wider public services and civil society are required to move beyond islands of good practice in tackling poverty. Each of our examples – in our view – has thrived and been successful because they have demonstrated one or more of these attributes, as Figure 21 shows (more details are available in Annex 1).

¹⁴⁶ See chapter 3, http://www.kingsfund.org.uk/sites/files/kf/field/field_document/health-inequalities-general-practice-gp-inquiry-research-paper-mar11.pdf and <http://www.bbbc.org.uk/our-mission-and-model>

Figure 21: The NHS and tackling poverty – enabling uptake of good practice

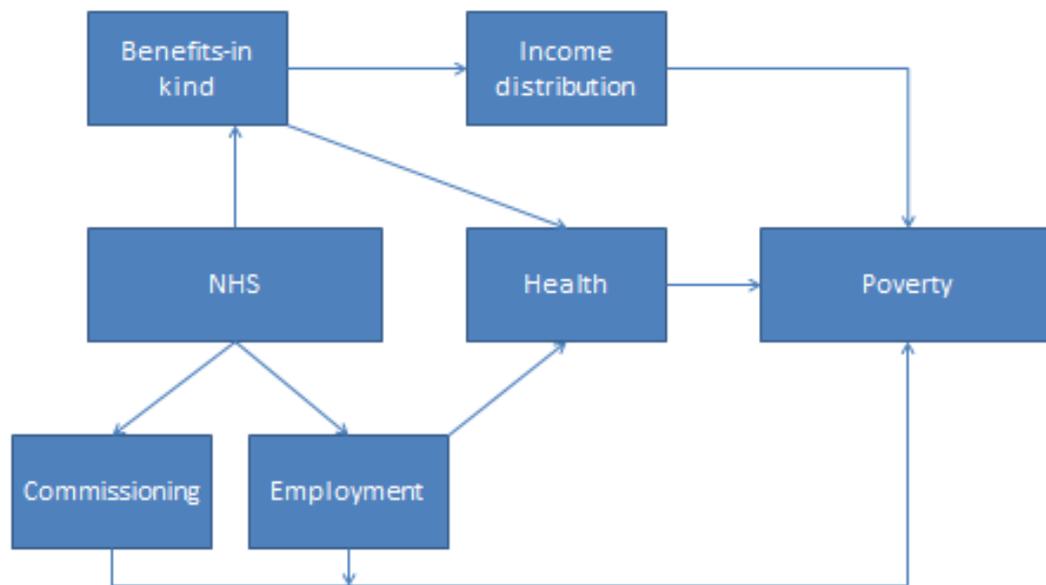


But to change and spread this good practice more widely requires a much greater awareness of where the NHS already tackles poverty: where it can do more, and how to get there. How do we help make these case studies the norm, not the exceptions? We set out recommendations below.

7. Summary and recommendations

While Figure 2 still remains relevant as a high-level conceptual framework for the health and poverty cycle, our review allows a more specific framework for future analysis of how the NHS impacts on poverty. Figure 22 brings together our understanding, developed during this review on how the NHS can better tackle poverty.

Figure 22: The NHS and its effects on poverty – A simple framework for policy analysis



What the review has revealed is that although the NHS affects poverty through its impact on health (via receipt of in-kind health care services) and in how services are designed for patients (for instance, those with LTCs), it has a much wider impact beyond this.

It effectively narrows income inequalities by about 13 per cent and has huge potential to impact on poverty more positively through its employment, its economic scale in every community and its commissioning – particularly in the context of the Social Value Act – as well as in the details of how NHS resources are allocated to different parts of the NHS.

Yet, throughout our analysis, it is clear that much of this is often not ‘seen’ by the NHS on the ground, and is very little talked about by its system leaders. We have reviewed the reasons for this – some are deeply seated and cultural. There are encouraging signs in some aspects of the reforms, and in the response of key professional groups to Michael Marmot’s work on the social determinants of health. But for the NHS to maximise its potential to

tackle poverty it needs a much greater alignment of its system levers, a widely shared and accepted 'poverty narrative' and wider engagement with local partners and civil society.

We have outlined in this paper some of the steps to help it get there. In order to support that further we recommend the following action.

❖ JRF should

- seek to raise awareness of the NHS's *existing* role in tackling poverty in government policy circles and within the NHS itself in order to ensure that the NHS's current impact is at least maintained. The conceptual framework in Figure 26 could be useful for this alongside the information on the NHS role in effectively narrowing income inequalities, and its economic multiplier effect.

❖ NHS England should

- lead on the development of a narrative for the NHS's role in tackling poverty. This should include, but move beyond, the role of the NHS in *adapting* to poverty, and set out its role in mitigating, reducing and preventing poverty. The narrative should explain how the levers (as set out in sections 3.2 and 4) can be better aligned for tackling poverty and develop compelling vignettes for local health economies to help them 'see' their contribution to tackling poverty.
- create and disseminate a catalogue of good practice (drawing on section 6) on the NHS's role in tackling poverty
- with the NHS, produce guidance for the NHS on what the Social Value Act implies for commissioning NHS services
- audit the wider economic impact of the NHS in local areas, and its redistributive effects, building on the work in section 3.2.3 on the relative economic performance of the NHS in local economies
- ensure that resource allocation accurately reflects the circumstances and needs of those in poverty *and* hold the NHS to account for the use of these resources
- ensure that the narrative, policy and practice guidance and future pilots on LTCs and integration includes how services need to adapt to take into account the socio-economic circumstances of patients.

❖ Local health partners (particularly the NHS and LAs) should be further challenged to

- pay the living wage as a default and stipulate this in commissioning

- work more creatively and closely with other public bodies, through fairness commissions and similar mechanisms to ensure the NHS contributes to wider poverty and wellbeing objectives
 - understand and act on the implications of the Social Value Act for commissioning, and its relationship with tackling poverty
 - include assessments of the local NHS's impact on poverty in JSNAs and joint health and wellbeing strategies.
- ❖ Clinicians and their leadership bodies should
- commit to *Working for Health Equity: The role of health professionals* recommendations and undertake an audit of achievements
 - ensure that the social model of health is given as much status as the medical model in training, and in continuing professional development.
- ❖ The Department of Health should
- reconsider how the NHS can do more for poverty through the NHS Mandate, and the NHS, public health, social care and associated outcomes frameworks
 - work more closely with other departments (particularly the DWP) to ensure that people at risk of – or with – LTCs and mental health problems are supported to keep in the workforce
 - with partners (NHS England and Public Health England), model and understand more deeply the impact of the NHS on poverty at national and local authority level through an internal or commissioned piece of work – and include this as a benchmarked indicator through the NHS and public health outcomes frameworks.

Annex 1: Case studies

The NHS and tackling poverty – good practice examples

System design and levers

These are not examples as such but critical components to enable the NHS to maximise its effect on poverty.

a) The NHS as a direct provider of services

As reviewed, the way the NHS is designed affects the way it provides health care services and affects how it adapts to poverty. There are significant challenges, including its approach to LTCs. See section 1.1.3.

b) The NHS as an employer and as a commissioner

As reviewed, the NHS has an impact on poverty through its employment practices. It needs to do much more as a system to ensure that its commissioning demonstrates social value. See section 2.2.

c) The NHS – benefits in kind

As reviewed, the funding and delivery model of the NHS already means that it has a significant impact on income inequality, and therefore on poverty. There is very little awareness of this in public debate, or within the NHS itself. See sections 1.2.1 and 2.1.

Specific examples

d) Derbyshire community paediatric services

The Derbyshire community paediatric service underwent a complete remodelling to ensure that children and young people living in deprived circumstances, particularly those in the poorest and most vulnerable categories, received equitable access to care. Derbyshire targeted children with special educational needs, those in need of safeguarding or in care, travellers, asylum seekers and refugees, and young offenders. Care was offered in places close to home and school, using a multi-agency approach and an open referral system (mostly from health visitors and school nurses). Following the remodelling, more than two-thirds of patient contacts are with children in the most deprived two-fifths of the population, a group that represents more than half the local child population and the traditionally hard-to-reach children.

In Derbyshire we see that leadership from the community paediatric service, along with wider engagement with other public services (particularly the education system) has enabled the service to adapt to the needs of the most vulnerable children in the area.

e) Great Chapel Street, Westminster

Great Chapel Street is a walk-in medical centre provided by the NHS for homeless people in Westminster. It has a holistic approach to tackling health issues. The team includes GPs, and a practice nurse, substance misuse/mental health specialist, counsellor, dentist, psychiatrist, benefits advice worker, and an advocacy/legal advice worker.

Often working with external partners, the service aims to:

- reduce social exclusion – to improve access for homeless people to health services and to act as a point of contact for mainstream medical and social services
- reduce health inequality – to improve the health of the homeless population by recognising and addressing the multiple social and medical needs of this patient group.

Working with the poorest and arguably most vulnerable group, homeless people, Great Chapel Street is an example of where NHS services have adapted to reach out to a specific group of people in poverty. Although the service works with other external partners, it is unclear how much interaction Great Chapel Street has with other public services (for example, housing, education, etc).

This service has developed as a result of the system design, and levers available to the service providers. It is an adaptive strategy, which will of course mitigate some of the health implications of poverty, but it is not focused on prevention (particularly given the patient population).

f) Homerton Hospital Housing Service

The team at Homerton University Hospital provides care and treatment for patients diagnosed with TB. North-east London has some of the highest rates of TB in England and Wales, as well as the most ethnically diverse and poorest wards in the country. TB treatment takes a minimum of six months before a patient is cured. Patients with drug-resistant TB need to remain on treatment for between 9 and 24 months. A significant minority of these patients have no recourse to public funds for a range of reasons. Because of this, levels of homelessness among this group are high, with most of them ‘sofa-surfing’, squatting or sleeping on the streets.

Homelessness is a major factor in any failure to treat this vulnerable population, whose daily priorities tend to centre on finding a place to sleep and food. Because of the transient nature of the population, they become ‘hard to reach’ in terms of adherence to treatment. As with all antibiotics, not taking the full course of TB treatment can result in developing drug resistance to the treatment, as well as reactivation of disease. Non-completion is costly, in terms of the health of both the individual and their contacts, and to the NHS. In order to break this cycle of high cost and ill health, the TB team decided to try to negotiate a service-level agreement with the local Homeless Persons Unit in the London Borough of Hackney, which would offer rapid housing for these patients for the duration of their TB treatment.

This is a clear example of a focused intervention by the NHS, albeit one which stops short of prevention. It is clearly an adaptive strategy which is likely to mitigate and reduce the impact of poverty. This is also a great example of where system leadership and culture married with wider engagement with public services is absolutely pivotal to the NHS having a better impact on poverty.

g) Inclusion Healthcare Social Enterprise CIC

Set up and run by a nurse and a doctor, social enterprise Inclusion Healthcare focuses its work on delivering care to homeless people and other vulnerable groups. The service, which is commissioned by the NHS, offers registration to homeless people, residents of two approved hostels, residents of two learning difficulties units, and women working in prostitution. In December 2010 they began delivery of a full range of primary health care services, including health education, promotion and screening to a highly vulnerable group of adults with moderate and severe learning disabilities. This is particularly important because the team has identified that people with learning disabilities may die from manageable LTCs. The team's aim is to improve health outcomes for this group of patients by ensuring timely interventions and proactive care.

In November 2013, Inclusion Healthcare and Leicestershire and Rutland Probation Trust partnered to take over the Anchor Centre, a 'wet' centre for street drinkers. This service also includes housing advice, including referrals to emergency and longer-term housing, and pre-tenancy support. It has a weekly GP surgery on Thursdays, IT classes, and a general activities programme (facilities include: lounge, coffee bar, television, phone, computers and internet access, showers, clothing store).

Through its commissioning powers (system design and levers), the NHS has chosen a service which clearly focuses on reducing the impact of poverty on homeless people in Leicester – as well as other vulnerable groups. The partnership between Inclusion Healthcare and Leicestershire Probation Trust is a clear example of how the NHS can engage with wider partners. This model of best practice is enabled by all three components – clear leadership, system design and engagement with other public services.

h) Queens Nursing Institute – food, nutrition and homelessness

This toolkit, developed by a dietician in partnership with the Queen's Nursing Institute, looks at a healthy diet and the key issues and barriers faced by homeless people (single and families) in the context of food and healthy eating. The purpose of the guidance is to help practitioners recognise and screen for nutritional need among single homeless people and families. It also contains information on tools that frontline workers can use to screen for malnutrition in single homeless people or homeless families with dependent children.

This is an initiative of good practice which comes from outside the NHS, but impacts on clinicians and practitioners in the health service who come into contact with homeless people. As a learning resource for clinicians and others, this toolkit helps the NHS adapt to the needs of a specific population in poverty. It is also an example of how system leadership (in this case from the Queens Nursing Institute) alone can have an impact on poverty.

i) Family Nurse Partnerships (early years)

The Family Nurse Partnership (FNP) is a targeted programme for vulnerable, young, first-time mothers, which involves intensive and structured home visiting from pregnancy until the child is two years old. The FNP has three main aims – to improve pregnancy outcomes, child health and development, and parents’ economic self-sufficiency. This is achieved by building a strong relationship between the family and the family nurse, which helps to achieve benefits such as:

- improved early language development, school readiness and academic achievement
- reductions in children’s injuries, neglect and abuse
- improved parenting practices and behaviour
- increased maternal employment and reduced welfare use.

As a national programme developed at the system-level (the Department of Health), the FNP is a model centred on the early years of the lifecycle. This concerted effort and allocation of resources by the NHS in England is focused on mitigating (current) and preventing future (child) poverty. The outcomes for the programme have proved to be very successful in achieving its aims. This model is an example of what system leadership and system design alongside engagement with other public services can achieve.

j) Sheffield Citizens Advice Bureau – welfare rights and support in a mental health setting

The Sheffield Citizens Advice mental health service is one of only two services dedicated to the advice needs of people with severe mental illness. Based on hospital grounds, it supports around 600 people with severe mental illness throughout Sheffield. Just under half of these people are seen as inpatients, with the remainder living in community settings. The service focuses on resolving complex welfare problems involving legal or other issues.

A recent analysis of the Sheffield service concluded that specialist welfare advice can cut the cost of health care (and inversely counter the possible effect of mental health issues on the users’ level of poverty) in three main ways.

- Reductions in inpatient lengths of stay: through resolving complex housing problems such as possible eviction or repossession.
- Prevention of homelessness: as people with mental health issues are at a much higher risk of homelessness than average, a specialist advice service can help to prevent this, for example by negotiating directly with landlords and creditors in case of rent arrears.
- Prevention of relapse: severe mental illnesses such as schizophrenia and bipolar disorder are LTCs. Relapse is common and costly. However, there are a number of ways a welfare advice service can help to reduce the risk of relapse (vulnerability stress model).

The model of care in Sheffield is an excellent example of an external organisation (Citizens Advice Bureau) contracting with the NHS to reduce and even prevent poverty for those with mental health issues. In this particular case, this has required leadership from within the NHS and the external organisation, engagement between the NHS and other public bodies,

and finally the system design and levers – which enabled collaboration between the two partners.

k) Bromley-by-Bow Centre

Bromley-by-Bow Centre provides a range of services designed to tackle social and economic inequalities in the local area. These are linked to the Bromley-by-Bow Health Centre, which takes a holistic approach to health, with the following activities:

- referring patients to employment programmes, benefits and housing advice, educational opportunities, art and design activities, and social enterprises, all available on site
- providing an integrated approach to health services, promoting health and wellbeing, and delivered by GPs, practice nurses, health visitors, district nurses and support staff and administrators
- linking with the Children’s Centre, the teenage parent support project and the health trainers’ programme, which are all also provided by the Bromley-by-Bow Centre.

Often heralded in health policy circles as the best practice model to replicate, the Bromley-by-Bow Centre clearly adapts to but also (through work with other agencies) impacts on poverty, in terms of reduction and prevention. This model has developed through committed leadership, an ability to design a service within the confines of the overall system and levers, as well as a clear commitment to work with other agencies (particularly education and housing services).

l) Cares of Life¹⁴⁷

The Cares of Life service provides a holistic approach to mental health care delivery for black and minority ethnic communities living and/or working in Southwark. The aim is to devise and deliver culturally appropriate services to meet the needs of those who access the mental health service. Cares of Life provides presentations, workshops and mental wellbeing training (from a cultural perspective) to local agencies, statutory and community services, as well as signposting families to appropriate services and organisations.

Given the link between mental health and poverty, we found Cares of Life to be an innovative approach led by the third sector which will have an indirect impact on poverty through delivery of services by health care professionals. Although not initiated from within the health care service, it engages the NHS with public service agencies and third sector providers to deliver services in an innovative way.

m) Bridging the Gap – a health inequalities learning resource

NHS Education for Scotland has produced an online health inequalities learning resource named Bridging the Gap aimed at nurses, midwives, and allied health professionals. The

¹⁴⁷ This service may have closed, we are clarifying the position.

resource is primarily aimed at pre-registration students. On completing the course, students will be able to:

- outline the wider determinants of health and their significance for understanding the causes and effects of health and social inequalities
- outline legal and policy drivers for eliminating discrimination, promoting equality, human and patient rights in NHS Scotland
- discuss cultural, institutional and cultural actions that NHS Scotland can take to challenge health inequalities
- outline personal and professional roles, responsibilities and rights in relation to eliminating discrimination, promoting equality, human rights and good relations.

Bridging the Gap is a good example of system leadership in NHS Scotland to educate its nurses about the causes of and drivers for eliminating health inequalities (which indirectly captures those in poverty). This kind of system leadership and culture-changing approach is to be applauded. However, it is less clear how much impact (other than an adaptive strategy in terms of training nurses) this has overall on poverty.

n) Leeds School of Medicine – medical education and training

Leeds School of Medicine is one school in which the social determinants of health and health inequalities teaching have been given greater attention. This includes:

- bringing in external expert organisations to give workshops and teaching on the social determinants of health
- visits for first- and second-year students to voluntary and community groups close to GP placements
- placements for second- and third-year students with voluntary and community groups
- podcasts for students on poverty and the social determinants of health
- an emphasis on the importance of communication and interpersonal skills.

Much like Bridging the Gap, the system leadership we see from the Leeds School of Medicine is to be commended for approaching health inequalities and poverty (indirectly) through a change in culture for future doctors. While we were less clear of the tangible outcomes of this approach to medical education and training, this integral understanding of the causes, consequences and interventions in terms of poverty is central to the NHS becoming more focused on poverty in the near future.

o) Kids Company – Arches II

Kids Company, founded in 1996, provides practical, educational and emotional support to vulnerable inner-city children. Arches II is a street-level crisis centre in Lambeth where Kids Company supports more than 2,200 vulnerable children and young people. Their practical and emotional needs are met on site by a team of key workers, social workers, youth offending workers, teachers, employment advisers, psychologists, nurses, alternative health therapists, art therapists, and a GP. Ninety-five per cent of the children and young people

accessing the service refer themselves; these are the children that local authorities often struggle to manage, because their behaviour is so disturbed and their needs so complex.

Arches II, through providing services that are accessed, designed and delivered according to the individual service user, ensures that each child is given a comprehensive package of care. In 2008, the University of London conducted a study of children and young people who attended Arches II. In a random sample of 240 young people, the study found:

- 81 per cent had been re-integrated into education, training or employment
- 86 per cent were engaged in work experience
- 90 per cent had reduced their criminal activity
- 94 per cent had reduced their level of substance misuse.

The Arches II model is another example of a third-sector organisation collaborating with the health service (in terms of health therapists and GPs) to reduce the impact of poverty. In this model it is likely that the focus on child poverty has come from outside the NHS. Nonetheless, the health service has clearly adapted the way it provides care – particularly within a multidisciplinary team – to affect and prevent long-term poverty. The health care service is encouraged to lead from the front on initiatives such as Arches II to affect poverty overall. Engagement with public services and other stakeholders was a key factor enabling adaptation and prevention.

p) Poverty: A clinical tool for primary care in Ontario

The Ontario College of Family Physicians produced a suite of clinical tools to address poverty in primary care.

The main toolkit sets out three ways to address poverty in primary care.

- Screen – this involves determining whether patients are experiencing any ‘difficulty making ends meet at the end of the month’, or experiencing any level of poverty.
- Adjust risk – this requires doctors to factor poverty in to clinical decision-making like other risk factors. For example, doctors are asked to consider (in their treatment options) the increased prevalence of diseases and illnesses associated with poverty (cardiovascular disease, cancers, hypertension, diabetes, mental ill health).
- Intervene – this is where doctors provide complete and detailed information about the welfare programmes available to their patients, referring patients to relevant welfare agencies where appropriate.

We have included this international model of practice to highlight what in particular doctors can do to affect poverty. We commend this model for its clear focus on poverty, and on the role of doctors to reduce poverty via welfare rights and benefits advice for those in poverty. The key enabler for this model is leadership in the form of the Ontario College of Family Physicians who developed the toolkit for primary care doctors in the region.

q) University College London – medical education and training

The University College London Target Medicine programme is a widening participation project delivered by UCL medical students, supported by academic staff. The aim is to inspire students from non-selective state schools and support them to apply to medical school. The scheme involves:

- mentoring: UCL medical students run sessions with sixth form students who would like to study medicine (sessions include information and support on personal statements, interview skills, assessments and A-level revision classes)
- outreach activities: aimed at younger, pre-GCSE pupils (Years 8 and 9), current medical students give presentations to inspire school students to consider studying medicine.

Summer School: This is a week-long scheme for Year 11 pupils who have the opportunity to take part in mentoring activities, meet patients, nurses and doctors, visit a hospital and engage in simulated emergency clinical situations.

The UCL outreach model is a great example of system leadership and engagement with the education system work together to reduce and even prevent (long term and future poverty). Furthermore, developing methods for those in lower socio-economic groups to enter the medical profession will have an impact on its overall culture and approach to the issue of poverty.

r) Blackburn and Darwen – Social Value Assessment Tool

In 2012 Blackburn with Darwen Care Trust Plus (PCT) working with NHS commissioners, the local authority and the community and voluntary sector established a group to develop and test a 'Social Value Self-Assessment Tool'. This was designed to enable providers to demonstrate the added social value they were creating. For more information about this case study, please see page Box 3, section 4.2.

s) Derbyshire GPs and the Citizens Advice Bureau

A local PCT in Derbyshire commissioned the Citizens Advice Bureau to provide a limited advice service in a couple of GP surgeries in 1995. After a slow start the service proved to be popular with patients and GPs. It was progressively scaled up and now covers 98 out of 102 practices in the county, with a weekly 3-hour advice session in each practice, staffed by paid members of staff. It is currently funded by Derbyshire Council Public Health. The project puts free advice at the heart of a largely rural community; it gives GPs and practice staff another referral option to a service based physically within their own practice. For more information about the experience in Derbyshire, please see relevant box, section 6.1.

t) GPs at the Deep End, Glasgow

‘GPs at the Deep End’ was devised by academics and community GPs and works in the 100 most deprived populations in Scotland. The project acknowledges that while the ability of health care to change the social conditions that lead to ill health is limited, health care is nonetheless a social determinant and doctors are part of the social capital of communities. For further information on ‘GPs at the Deep End’, please see relevant box, section 5.2.1.2.

u) Guys’ and St Thomas’ NHS Foundation Trust

Guys’ and St Thomas’ NHS Foundation Trust runs a range of programmes, including a ‘get into work with the NHS’ with The Prince’s Trust, targeting 16- to 24-year-old NEETs within the local community. This programme involves a three-week intensive work programme, work buddies and mentors, and aims to develop skills and experience. The trust also has 16 partnerships with local schools, taking young people on work experience. Partnerships include work with Southbank Employers’ group and their employment and referral centre Waterloo Jobshop, to deliver an employer-led recruitment programme to meet the Trust’s needs and demands, while reducing the numbers of long-term unemployed in the local area. See relevant box, section 3.1.2.

v) Glasgow and Clyde – Healthier, wealthier children

The purpose of this project is to test whether there are unmet financial inclusion needs for families with children involved with the NHS and to mainstream an approach to this. It offers income maximisation advice for families experiencing child poverty and will aim to prevent families from falling into child poverty by working with health and early years services to identify families at risk at an early stage. Consequently the main service groups targeted for providing referrals to Healthier, Wealthier Children income maximisation services include midwives and other antenatal service staff, health visitors, oral health and breastfeeding advisers, and parenting support workers. For more information on the work in Glasgow and Clyde, please see relevant box, section 3.1.3.

w) Fairness and health in Liverpool

In 2012 the Liverpool Fairness Commission (LFC) was set up to consider how to build a fairer future in light of the current austerity measures. As part of the LFC, Liverpool’s mayor set up a health commission to determine how best to support and improve the health and wellbeing of the people of Liverpool. The Liverpool model is an example where the NHS is brought into tackling the structural causes and consequences of poverty as a key stakeholder in a city-wide strategy. For more information, please see relevant box, section 5.2.3.