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# The impact of the economic downturn and policy changes on health inequalities in London

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UCL Institute of Health Equity



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Written by the UCL Institute of Health Equity for the London Health Inequalities Network

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UCL Institute of Health Equity

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## Foreword

Health inequalities in London are stark. Between London boroughs there are life expectancy gaps of 9.1 years for men and 8.7 for women, and healthy life expectancy gaps of 11 years for men and 10.5 for women. Within borough differences can be even bigger – the difference between men in the tenth of the population with the worst and the tenth with the best life expectancy in Westminster is 17 years. Across England health inequalities are widening. The reasons for such large and widening inequalities relate to inequalities in the social determinants of health, the social and economic factors which shape peoples' lives and their health. In this review we assess three important social determinants of health – housing, income and employment – and their likely impact on health inequalities in London in the context of the ongoing economic crisis and the Government's welfare reforms.

This literature review is the first stage in work aimed at assessing and monitoring the impact of the recession and welfare reforms on health inequalities in London and it makes for sober reading. Improving health and reducing health inequalities in this macro-economic environment is going to be a great challenge. Rising unemployment, poorer working conditions, depressed incomes and an inability to pay for decent housing and basic needs will all increase negative mental and physical health outcomes across the social gradient and especially for more vulnerable groups. Those unemployed for long periods of time will be more likely to be unemployed in the future, and higher levels of parental stress will lead to worse outcomes for many of the children of this generation.

The report highlights the importance of sufficient incomes, decent housing and active labour market programmes, focused on those groups most at need. But how can cash-strapped boroughs make this happen? This report provides suggestions, and will be used as the basis for local tools to enable targeted action on the priority risk areas. Over the coming months, an indicator set will be developed to measure potential impacts of the changes. This should assist boroughs planning services and anticipating the health and well-being of their populations.

National Government should carry out health equity impact assessments of all policies. It needs to review the impact of the welfare reforms in light of this report, and emerging evidence, regarding people's health status and inability to make ends meet. The welfare reforms taken as a whole seem likely to exacerbate the effects of the recession in

London, and for many vulnerable groups, this will lead to an increase in ill health and mortality.

Of course, it isn't news that recessions cause unemployment and suppressed incomes. By definition, growth is lower, and demand for products and services lower. However, at the same time, there is still great wealth within London. Where money is available, providing people with the security of a minimum income for healthy living will not only save lives, but should also stimulate demand led growth.



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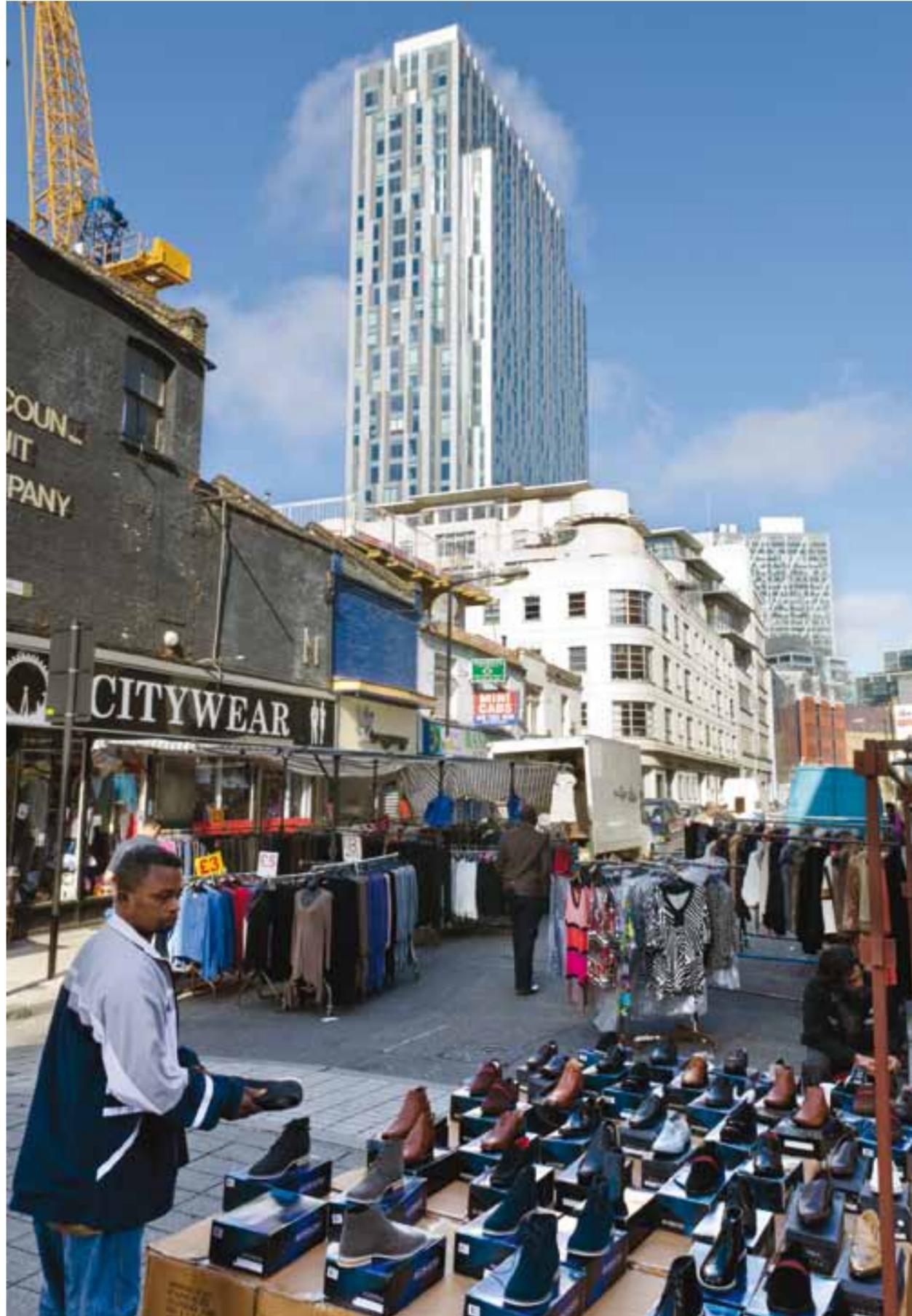
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## Executive Summary

**London has large inequalities in mortality and health.** Avoidable health inequalities related to socioeconomic deprivation exist between and within London boroughs. For example, male life expectancy ranges from 76 years in Islington to 85.1 years in Kensington and Chelsea and there are within-borough inequalities in male disability-free life expectancy (DFLE) of 18.1 years between the least and most deprived neighbourhoods within Kensington and Chelsea (1). Figures 1(a) & 1(b) show the average male and female life expectancy in each London borough, ordered by their rank on the Index of Multiple Deprivation (IMD). The graphs show that, generally, the greater a borough's average levels of deprivation, the lower its average life expectancy.

**Action to reduce health inequalities needs to focus on the social determinants of health.**

Health inequalities are closely related to social and economic inequalities. Therefore, action to reduce health inequalities requires action on all of the social determinants of health: the conditions in which people are born, grown, live, work and age (2). There are many actions that will help to tackle health inequalities, as outlined in *Fair Society, Healthy Lives (The Marmot Review)* (3). Ensuring that health equity is at the heart of all policies through robust health equity impact assessments will encourage progress towards reducing health inequalities across all of the social determinants. There is much that local government can do to reduce health inequalities in their area and to dampen the impacts of social and economic factors that might otherwise increase these inequalities.

**This report summarises the likely impacts of the economic downturn and recent welfare reforms on health inequalities in London.**

The report's aim is to assist local authorities in London to identify and mitigate negative impacts of the economic downturn and national welfare reforms on health inequalities and the social determinants of health, particularly employment, income and housing impacts, by providing the following:

- 1 A review of existing literature on the likely impacts on health inequalities of economic, policy and demographic changes in London in the period to 2016, through identifying the impacts of the changes specifically on employment, income and housing
- 2 Some recommendations regarding what local authorities could do to minimise any negative health effects resulting from the changes.

**The report forms the basis for tools that will enable local areas to mitigate the impact of the downturn and welfare reforms.**

A set of indicators that local authorities should use to monitor the impact of the changes is in development and will undergo local testing before being made available in early 2013.

**The impact of the economic downturn on health and health inequalities**

**Evidence from previous economic downturns suggests that across the population there will be short term and long term health effects.**

Evidence from previous economic downturns indicates the following health impacts that might be anticipated in London:

- More suicides and attempted suicides; possibly more homicides and domestic violence (4–11)
- Fewer road traffic fatalities (4;12)
- An increase in mental health problems, including depression, and possibly lower levels of wellbeing (13–18)
- Worse infectious disease outcomes such as tuberculosis and HIV (19)
- Possible negative longer-term health effects (20;21).

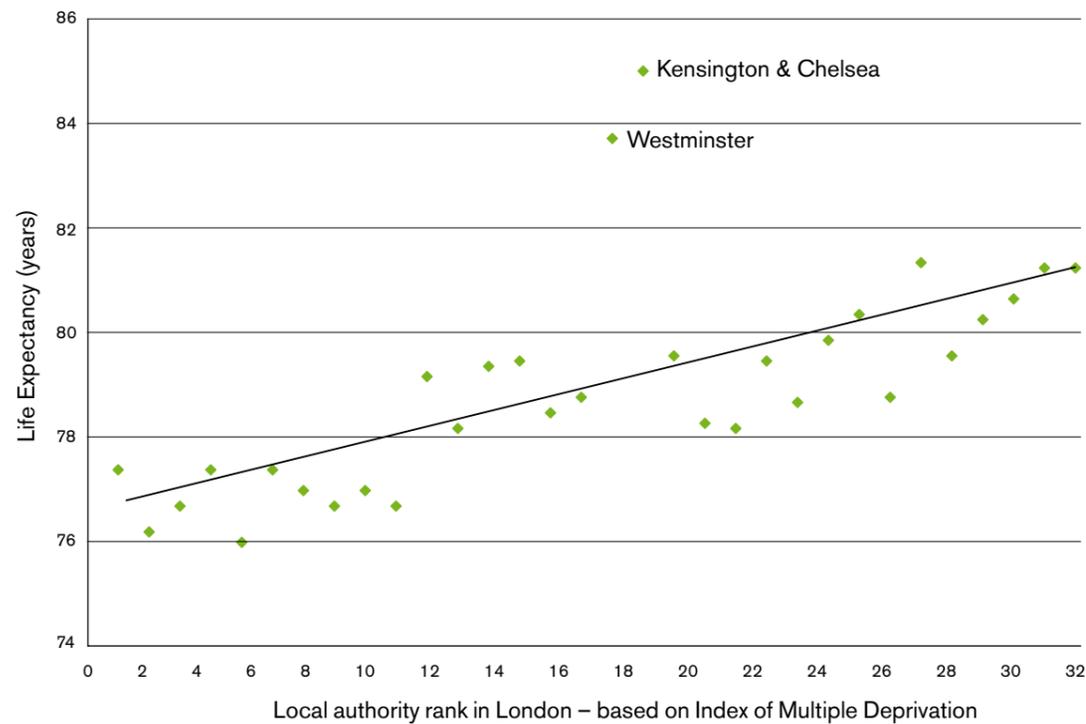
**Health inequalities are likely to widen.**

An economic crisis is likely to have a significant impact on the social determinants of health. Evidence from past recessions suggests that inequalities in health according to socioeconomic group, level of education and geographical area are likely to widen following an economic crisis (22–24).

**At the same time as the downturn, the government has implemented a welfare reform package.**

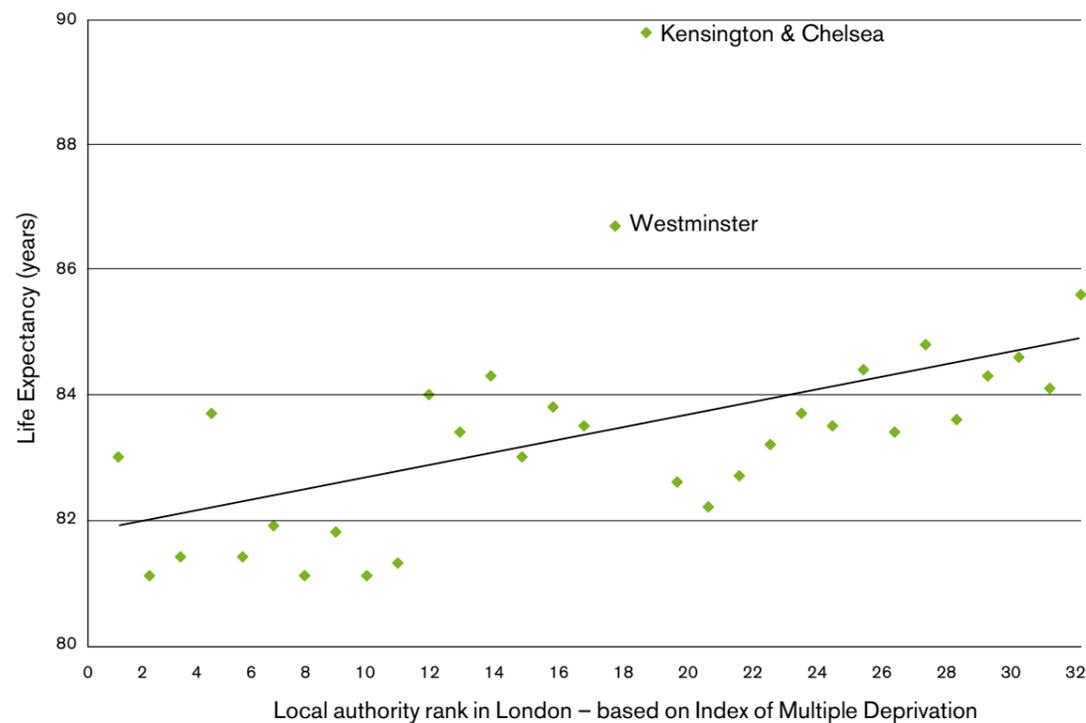
Government policies and the extent of social protection will play a substantial role in exacerbating or mitigating the negative health and inequality impacts of economic decline, particularly for the most vulnerable (12;25;26). The government has introduced £18 billion of welfare savings as part of its austerity programme and has suggested there may be £10 billion more to come by 2016 (27).

**Figure 1(a)** Life expectancy at birth for males for each London local authority, 2008–10, ordered by rank on the Index of Multiple Deprivation



Source: Office for National Statistics (1)

**Figure 1(b)** Life expectancy at birth for females for each London local authority, 2008–10, ordered by rank on the Index of Multiple Deprivation



Source: Office for National Statistics (1)

**The employment and health impacts in London as a result of the economic downturn and welfare reforms**

**Unemployment is bad for health.**

Unemployed individuals, particularly the long-term unemployed, have a higher risk of poor physical and mental health compared with those in employment, and unemployment is associated with unhealthy behaviours such as increased smoking and alcohol consumption and decreased physical exercise (3;15;28). The health and social effects resulting from a long period of unemployment can last for years (29;30).

**The unemployment rate in London has increased.**

The unemployment rate in London has increased dramatically, from 6.7 per cent per cent in the second quarter of 2008 to 10.1 per cent per cent in the first quarter of 2012, and the recovery is expected to be slow (31–33).

**London has several groups that are particularly vulnerable to unemployment.**

Particular groups are more vulnerable to unemployment than others, and initial analysis of the current downturn across the UK suggests that young people (under 25), men, those with lower-level skills or education, and employees of certain sectors, have been disproportionately affected by unemployment (34;35).

More deprived areas of London have higher proportions of young people not in employment, education or training (NEET) compared to the 16.2 per cent England average: for example, in East London 18 to 20 per cent per cent of 16–24 year olds are NEET, and for North-East London the rate is over 20 per cent (36). This is particularly concerning because early unemployment has a significant negative effect on employment opportunities later in life (37;38).

**Self-rated health can also be worse in an economic downturn for those who stay in work.**

Being in work is mainly protective of health when it is good quality work which gives employees some control over their work, rewards achievements, is safe and provides a decent standard of living (3). Worse self-rated health has been reported by those *in employment* during an economic downturn as well as those who are unemployed – perhaps due to higher levels of anxiety regarding job security, bigger work demands, financial problems resulting from pay constraints and lack of control over their work situation (39). Families and communities might also experience poorer health as a result of financial problems or psychosocial stressors caused by an individual’s unemployment (3;15).

**The government’s welfare reforms are intended to strengthen incentives to work, but there is a shortage of jobs.**

The welfare reforms are intended to strengthen incentives to work, therefore increasing employment

rates. Their success is conditional on effective incentives and sanctions, a sufficient number of jobs being available, and programmes to help those who need it to move into work. It is unclear whether or not the current reforms provide effective financial incentives and/or sanctions and conditionalities to encourage more people to take up work, though it appears that different groups are affected in different ways. For example, the tax and benefit changes introduced in 2011/12 have been shown on average to weaken work incentives for people with children, but strengthen incentives for those without children (40). Incentives to work will be far less effective if there are not enough jobs available and data indicates there are not currently enough in London for the number of people searching. The government’s new Work Programme is intended to help people find work. It is important that the focus is on sustaining people in good quality work and working effectively with vulnerable people and those furthest from the labour market to ensure they are work-ready.

**The income and health impacts in London as a result of the economic downturn and welfare reforms**

**Insufficient income is bad for health.**

Children born into poverty have increased risk of developing physical and mental health, developmental and social problems both immediately and throughout their life-course (3;41–43). Living in poverty is associated with worse mental health outcomes, particularly among women, though the relationship may be mediated by debt – a further determinant of poor mental health (3;44–46).

**Many Londoners are likely to see a future fall in income.**

The recent economic crisis has resulted in increasing unemployment, along with constricted social spending (including on social protection) and higher levels of inflation than income growth. This is likely to lead to a fall in income for many Londoners.

London has a much higher cost of living compared with the rest of the UK. The average income is higher, yet it drops to about equal to the national median once regional price variations are considered (47;48). Further, income inequalities are far wider than in the rest of the country, though they are unlikely to have increased during the economic downturn (35;49).

**More than half of Londoners live in households with an income below the minimum required for an acceptable standard of living.**

A minimum income for healthy living includes being able to pay for “needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene” (3). Households living on smaller amounts than this are likely to suffer poorer health outcomes than those on higher incomes. In 2005–08, more than half of Londoners lived in households with a weekly income below the minimum for an acceptable standard of living,

rising to more than 80 per cent for groups such as the Bangladeshi and Pakistani populations and lone parents (51).

#### The poverty rate is forecast to increase.

London has the highest poverty rates in England and the Institute for Fiscal Studies predicts that child and working-age poverty will increase across the UK over the next decade (52). Many London households are in debt, with 9 per cent in arrears with at least one domestic bill (53). Though overall levels of debt in the UK have not increased since 2008, the number of people seeking debt advice appears to have increased (53;54).

#### Many of those living in poverty live in working households: wages need to be sufficient for an acceptable standard of living.

Many of those in poverty live in working families (41). Receiving a 'living wage' will support the chances of an in-work household remaining above the poverty threshold and achieving the MIHL. The London Living Wage takes account of both the average income needed to achieve a minimum income standard and what constitutes 60 per cent of median income in London (55). For a particular household, achieving either standard depends on more than an individual's hourly rate – it is also affected, for example, by household composition, number of earners and their hours worked.

#### While Universal Credit is likely to be progressive, other tax and benefit reforms will mean that many households will need to live on lower incomes.

Many elements of the changes to the welfare system will mean that many households are financially worse off and will need to live on a lower income (see Appendix 1 for an outline of the main welfare changes). For example, the government predicts that 36,000 households in Greater London will have their benefits reduced by the household benefit cap in 2013/14, which will limit the total amount a workless household can receive in benefits (56). Universal Credit (UC), taken alone, is progressive and likely to reduce poverty, though there will be winners and losers at all income levels. However, when UC is considered alongside the rest of the tax and benefit reforms, poverty is expected to increase significantly more across the UK by 2015–16 than it would were the reforms not implemented (52).

The welfare changes are likely to impact low-income households, and in particular:

- Workless households and households in more than 16 hours per week of low-paid work (57)
- Households with children (40;58;59)
- Lone parents, more than 90 per cent of whom are women (possibly also women in couples) (60–63)
- Larger families (56;59)
- Some minority ethnic households (64)
- Disabled people who are reassessed and considered ineligible for the Personal Independence Payment.

#### The housing and health impacts in London as a result of the economic downturn and welfare reforms

##### Poor housing is bad for health.

Homeless people have a higher risk of physical and mental health problems. They are more likely to die from cancer or commit suicide, and their average age at death is just 40–44 years old. They also have higher rates of alcohol and substance misuse, smoking and tuberculosis (65–69).

Rates of respiratory disease, tuberculosis, meningitis and gastric conditions are higher in overcrowded households (70–72). Further, overcrowding can negatively impact children's education, family relationships, and physical, mental and emotional wellbeing (72).

Living in a cold, damp home leads to a higher risk of poor health outcomes, including cardiovascular and respiratory diseases and mental health problems, among all age groups (70;73). Living in a cold home also has indirect negative health impacts, for example on dexterity and children's educational attainment (73).

##### There is a shortage of affordable homes in London.

Housing problems are particularly acute in London because of a shortage of homes and high housing costs. High housing and energy costs, and energy-inefficient properties, detract from a household's disposable income with resulting health implications. Addressing London's shortage of affordable housing is crucial. The government and the Mayor of London have set targets for developing new affordable homes in London, though reduced public spending on housing highlights the difficulty of achieving these targets (74–76).

##### More people may be forced to live in poorer housing conditions which may constitute a risk to health.

Adequate housing may be more difficult to afford during an economic crisis and households may be forced to live in environments that may constitute a risk to health, such as homeless situations, overcrowded housing, and housing in a poor physical condition (77).

##### The number of homeless people has risen.

Comparing 2010 and 2011 data, the number of London households accepted as homeless by local authorities rose by 20.4 per cent (from 9700 to 11,680) (78). It was reported that the number of rough sleepers increased by 8 per cent, while the number of rough sleepers under 25 rose by at least 32 per cent (79).

##### The number of people living in overcrowded conditions has risen.

The number of children living in overcrowded housing increased by 18 per cent in London between 2008 and 2011 (80).

##### Over half a million Londoners live in fuel poverty.

Recent estimates suggest that at least 560,000 London households live in fuel poverty, meaning

they need to spend 10 per cent or more of their income on energy to heat their home (81;82).

##### Welfare reforms will make it harder for households receiving benefits in London to cover housing costs.

Overall, the welfare reforms will reduce the amount that households receiving benefits receive to cover rents, and London will be disproportionately affected compared with the rest of England because of the capital's high housing costs. Estimates suggest that between 82,000 and 133,000 London households will be unable to afford their homes following the reforms, with only 36 per cent of London's housing affordable to those receiving Housing Benefit by 2016, compared to 75 per cent before the reforms (59;83;84). There is considerable variation between different areas of London, which is discussed in the main report (85;86).

Families with children, particularly larger families, will be most severely affected, as will private tenants, as the majority of the changes only apply to them (56;87). Certain policies will cause disproportionate harm to certain groups – for example the up-rating of non-dependent deductions will particularly affect young adults.

##### Households unable to afford their current accommodation will need to find an alternative solution.

Rents might fall in response to the Housing Benefit reforms, particularly in areas with more benefit recipients – though landlords appear resistant to reducing their rents in the short-term (59;83). Households facing a reduction in benefits significant enough to make their current property unaffordable will need to find an alternative solution, most likely one of the following options:

- Take up paid employment (if available and pays enough)
- Re-negotiate the rent with their landlord
- Go into rent arrears leading to repossession or non-renewal of the tenancy
- Become homeless
- Become overcrowded
- Compromise on housing conditions
- Move to a less expensive area of the capital or out of London altogether.

##### London should expect significant migration within and between boroughs as more areas become unaffordable.

As a result of the welfare reforms, London might expect to see significant migration within and between different boroughs as more areas become unaffordable – including the likely polarisation of disadvantage – and/or an increase in homelessness, repossessions and overcrowding. Boroughs with higher levels of inward migration will receive increased demand from their own population, while areas with outward migration will face reduced demand. This may have wider impacts on services provision, community cohesion and physical and mental health, plus a worsening of a range of social and health conditions and widening inequalities (3;59).

#### How London's demographics might influence or be influenced by the economic crisis and the welfare reforms

##### London has high numbers of some groups 'at risk' of negative impacts from the welfare changes.

Particular groups identified in this report as being more 'at risk' from the economic and welfare changes are more commonly found in London than elsewhere and their numbers may be increasing. They include young people, minority ethnic and immigrant populations, and lone parent households.

##### Population growth will put extra pressure on housing and other resources.

London's population is predicted to increase from 2011's figure of 7.8 million to 8.06 million by 2016, and this increase will be higher in poorer areas (74). Population growth will put additional pressures on housing and other resources, at a time when these services are already under pressure from the macro-economic conditions, reduced budgets and within-London migration of Housing Benefit recipients. It is crucial that housing and other social services in London are sufficiently resourced to deal with these additional pressures.

## Conclusion

A number of recent reports illustrate that the effects that we are predicting, are happening across the country.

A number of recent reports illustrate that the effects that we are predicting, are happening across the country. Evidence from UK charity Mind indicates that mental health may have suffered in the economic downturn, with a 100 per cent increase on calls to its Infoline and Legal line on both personal finances and employment since the start of the recession (88). A report based on GP experiences in deprived areas documented concern regarding the number of patients with deteriorating mental health, noting that people were under more stress due to increased workload and job insecurity, and that those with chronic mental health issues who have had their benefits cut and are struggling to make ends meet, have increasing contact with GPs and Psychiatric services, more anti-depressant and antipsychotic use and increasing self-medication with drugs and alcohol (89).

Reports of financial hardship are also increasing. Practices reported cases of an elderly patient going to a friend's house in order to wash; families relying on relatives to pay for food and cigarettes (unable to stop smoking due to stress); and a mother resorting to prostitution to feed herself and her family (89). Camila Batmanghelidjh, founder and chief executive of Kids Company, said: "The number of children coming to us with hunger problems has increased five-fold in a decade and the number of children self-referring on a daily basis has doubled in the last year" (90). Citizen's Advice has also reported a big increase in people coming for help because they cannot afford to pay their gas and electricity bills (91).

Policymakers should consider both the overall health and social impacts of the economic and policy changes and which groups are likely to be most affected, when planning, prioritising and commissioning services. This report outlines some of the potential impacts on London households of the economic downturn and the welfare reforms, highlighting risks including: reduced benefits for low-income households; particular vulnerabilities of households with children; increased migration between different areas of London; and the health implications of higher unemployment. The recommendations in this report highlight possible ways to mitigate some of the negative impacts, while the indicator framework, to be published in early 2013, will provide a tool for local authorities to measure the impacts in their area, to help ensure that they respond in the most effective way.

# 1 Introduction

Local authorities in London will need to make difficult policy decisions in the coming years, in response to the economic climate and changes to national government policy, while accounting for demographic change across the capital. Local authorities face significantly reduced funding at the same time as increased demand for services and support and must decide which services are the most effective and necessary and therefore should be prioritised. The Health and Social Care Act 2012 will give local authorities a new leadership role for public health and the findings of this report will have implications for the NHS and public health outcome frameworks.

The UCL Institute of Health Equity was commissioned by the London Health Inequalities Network to produce a report that would assist local authorities in making prioritisation and commissioning decisions to reduce health inequalities during an economic downturn, by providing the following:

- 1 A review of existing literature on some of the likely impacts on health inequalities of economic, policy and demographic changes in London in the period to 2016, through identifying the impacts of the changes specifically on employment, income and housing
- 2 A set of indicators, based on the evidence from the literature review, that local authorities should monitor in order to measure the impact of the changes and respond accordingly
- 3 Some recommendations of what local authorities can do to minimise any negative health effects of the changes.

This report provides the literature review and the recommendations (the first and third items above). The set of indicators is still in development at time of publication and will be tested in a number of local areas before final publication in early 2013.

## Health inequalities in London

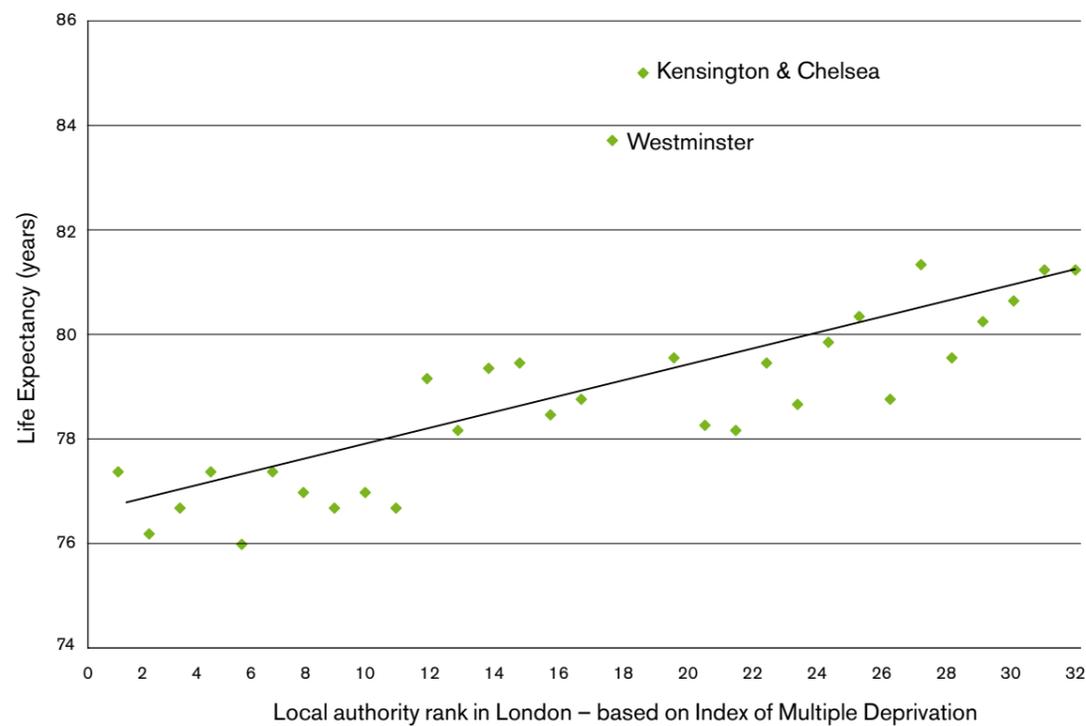
Within London, there are significant variations in physical and mental health outcomes between and within London boroughs. These health inequalities are mostly avoidable and unfair. Male life expectancy at birth ranges between 76 years in Islington and 85.1 in Kensington and Chelsea, and female life expectancy at birth ranges between 81.1 years in Barking and Dagenham, Lambeth and Newham and 89.8 years in Kensington and Chelsea (1).

Socioeconomic status relates closely to health outcomes and high levels of deprivation are associated

with poorer health. Figures 1(a) and 1(b) show the average male and female life expectancy in each London borough, ordered by their rank on the Index of Multiple Deprivation (IMD), with each green dot representing a London borough. The graphs show that, generally, the greater a borough's average levels of deprivation, the lower its average life expectancy. The line of best-fit shows the clear socioeconomic gradient in health in London – every borough except the wealthiest suffers some degree of health inequality related to its level of deprivation. The outlying boroughs of Westminster and Kensington and Chelsea are skewed because of factors such as the extreme inequalities within their populations which include many very wealthy households.

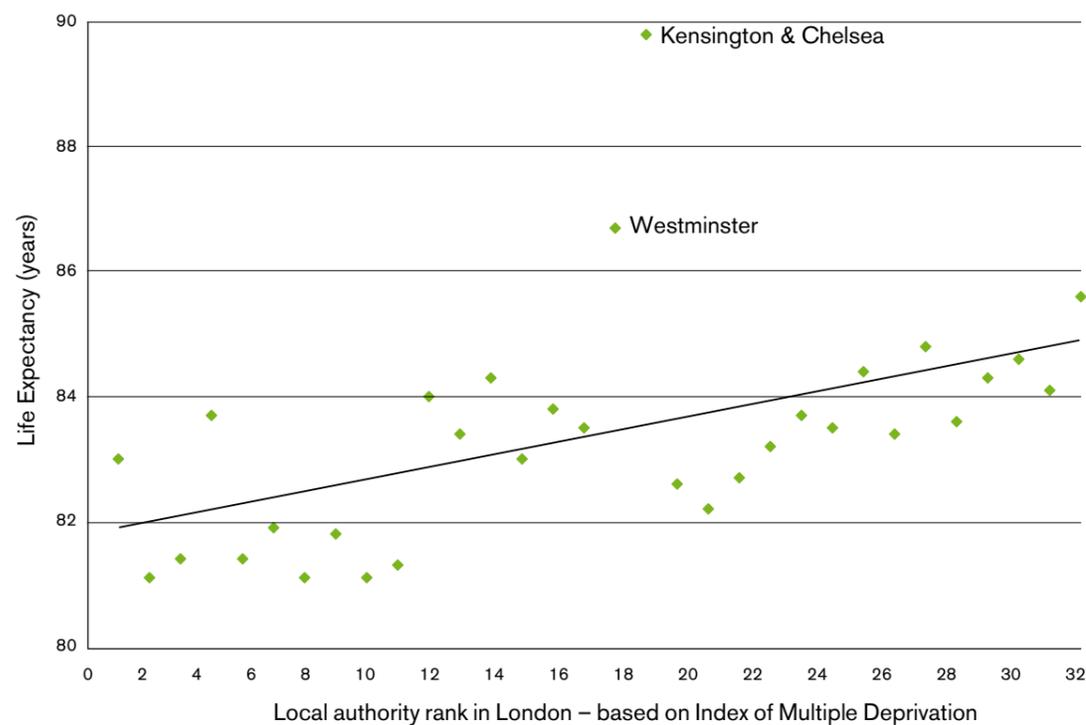
Health inequalities also exist *within* boroughs, with even the wealthiest boroughs having areas of high deprivation and poor health outcomes. Figures 2(a) and (b) show the boroughs with the largest and smallest inequalities in terms of the number of years that life expectancy differs between the least and most deprived neighbourhoods (otherwise known as the Slope Index of Inequality) (1). These inequalities exist within every borough. Figures for each borough can be found in Appendix 2.

**Figure 1(a)** Life expectancy at birth for males for each London local authority, 2008–10, ordered by rank on the Index of Multiple Deprivation



Source: Office for National Statistics (1)

**Figure 1(b)** Life expectancy at birth for females for each London local authority, 2008–10, ordered by rank on the Index of Multiple Deprivation



Source: Office for National Statistics (1)

These inequalities exist in morbidity as well as mortality, with disability-free life expectancy (DFLE) varying from 55.7/58.4 years in Tower Hamlets to 66.7/68.9 years in Richmond upon Thames (for men/women respectively) (1). There is an 18.1 year gap in male DFLE between the least and most deprived neighbourhoods within the borough of Kensington and Chelsea and a 17 year difference in Westminster (1). In 2006, 16.3 per cent of Londoners considered themselves to have a low level of mental wellbeing, though this ranged from 12.5 per cent to 20 per cent between the least and most deprived neighbourhood areas (51). Some population groups across London are particularly vulnerable to social and health inequalities, including travellers, the homeless and refugees and asylum seekers (3).

**The causes of health inequalities and how they can be addressed**

Health inequalities are the result of social and economic inequalities, and therefore action on health inequalities requires action on all of the social determinants of health: the conditions in which people are born, grow, live, work and age (2). The World Health Organisation (WHO)'s *Commission on Social Determinants of Health*, and *Fair Society, Healthy Lives (The Marmot Review)*, provided considerable evidence that social factors such as experience in early childhood, housing, education, income and the built environment are predictors of ill health, and improving these will have substantial impacts on a population's health and reduce unfair and avoidable health inequalities between and within populations,

cities and neighbourhoods (2;3). Inequalities in the social determinants of health contribute significantly to inequalities in health: for example, the percentage of children achieving a good level of development by age five in 2011 ranged from 50.3 per cent in Tower Hamlets to 70.1 per cent in Richmond upon Thames (1).

*Fair Society, Healthy Lives (The Marmot Review)* (3) recommended six overarching policy objectives which evidence suggests should reduce health inequalities in England. These were:

- 1 Give every child the best start in life
- 2 Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3 Create fair employment and good work for all
- 4 Ensure a healthy standard of living for all
- 5 Create and develop healthy and sustainable places and communities
- 6 Strengthen the role and impact of ill health prevention.

Within each policy objective was a set of recommendations to reduce health inequalities.

To reduce health inequalities and improve health for all, policy-makers should implement policies and programmes in a way that is designed to reduce inequalities in the social determinants across the whole social gradient in health. This is best achieved through universal policies implemented with a scale and intensity that is proportionate to the level of disadvantage. This approach has been termed 'proportionate universalism' (3). Furthermore, ensuring that health equity is at the heart of all policies through robust health equity impact assessments

**Figure 2(a)** Number of years difference in male life expectancy (LE) between least and most deprived neighbourhoods of the five local authority areas with the greatest and the five with the smallest inequalities

<b>Greatest inequalities</b>	<b>No. of years difference in LE</b>	<b>Smallest inequalities</b>	<b>No. of years difference in LE</b>
Westminster	16.9	Hackney	3.1
Tower Hamlets	12.3	Newham	5.0
Camden	11.6	Barking & Dagenham	5.2
Southwark	10.4	Lambeth	5.3
Croydon	9.5	Kingston upon Thames	5.8

Source: London Health Observatory (1)

**Figure 2(b):** Number of years difference in female life expectancy (LE) between least and most deprived neighbourhoods of the five local authority areas with the greatest and the five with the smallest inequalities

<b>Greatest inequalities</b>	<b>No. of years difference in LE</b>	<b>Smallest inequalities</b>	<b>No. of years difference in LE</b>
Westminster	9.7	Brent	1.2
Southwark	8.6	Barking & Dagenham	2.4
Greenwich	7.0	Redbridge	2.4
Wandsworth	6.8	Kensington & Chelsea	2.5
Enfield	6.3	Bexley	3.4

Source: London Health Observatory (1)

will encourage progress towards reducing health inequalities across all of the social determinants.

Based on this approach, this report considers the impact of the economic downturn and the government's welfare changes on three social determinants of health – employment, income and housing – in order to identify the resulting potential impacts on health and health inequalities, noting which sub-groups of the population might be most affected. It then considers what action might be taken by local authorities and other actors to mitigate these impacts, given that implementing local strategies, policies and interventions can make a real difference to reducing health inequalities. There is much that local authorities can do to reduce health inequalities in their areas and to dampen the impacts of social and economic factors that might otherwise increase these inequalities.

Local authorities should take into account the evidence base alongside their knowledge of the local area to make appropriate decisions in terms of prioritising and commissioning services. This report supports this approach by using the evidence review along with stakeholder consultation to develop a set of indicators, which will be published in early 2013. Local authorities will be able to use the indicators to monitor the impact of the changes in the social determinants of health, to understand the scale and cause of the problem in their area and plan accordingly.

#### Key points

- Avoidable health inequalities related to socioeconomic deprivation exist across London; for example, male life expectancy ranges from 76 years in Islington to 85.1 years in Kensington and Chelsea.
- Health inequalities are the result of social and economic inequalities. Action to reduce health inequalities requires action on all of the social determinants of health.
- The aim of this report is to assist local authorities in London to identify and mitigate negative impacts of the economic downturn and national welfare reforms on health inequalities, particularly with regard to employment, income and housing impacts, by providing a literature review and some recommendations for action.
- A set of indicators related to this review will be published in early 2013.

## 2 The impact of the economic downturn on health and health inequalities

“Austerity need not lead to retrenchment in the welfare state. Indeed, the opposite may be necessary”

— *Fair Society, Healthy Lives* (2010)

The current global economic crisis began with a banking crisis late in 2007. By September 2008 the UK had deteriorated into a recession which lasted until late 2009 and came back in early 2012. Low economic growth and rising unemployment have continued in the UK since 2007 and projections anticipate a slow and uncertain recovery (92). The unemployment rate rose to 8.4 per cent in the final quarter of 2011, though fell slightly to 8.2 per cent in the first quarter of 2012 (93). The latest Office for Budget Responsibility projections from March 2012 predict that unemployment will rise to 8.7 per cent in 2012 before falling to 6.3 per cent by 2016 (94). In London, the unemployment rate rose from 6.7 per cent in the second quarter of 2008 to 10.1 per cent in the first quarter of 2012 (31;32). In 2010 GLA Economics predicted a slow increase in employment of 315,000 to occur in London during 2010–20 (33).

An economic crisis has a huge impact on the social determinants of health, though the distribution of harm is likely to affect some – such as those who become unemployed or experience a sudden fall in income – more acutely than others. A brief review of the literature on the population health effects of economic crises can be found below. This highlights the variety of different health outcomes that might be influenced, both positively and negatively, by an economic crisis. However, looking at population effects does not identify who is worst affected or the impacts on health inequalities. Further, there is insufficient research into the longer-term health impacts of an economic crisis on a population, which are likely to be substantial given that unemployment and income effects are felt by individuals for some time after a recession and that the health impacts of unemployment often have a long time lag (11;29;30). This demonstrates the value of monitoring and analysing the social determinants of health (such as employment, income and housing), in order to identify and understand the likely health and health inequality impacts of an economic crisis.

Government policies, institutions and the extent of social protection provided by the state will play a substantial part in exacerbating or mitigating the negative health and inequality impacts of economic decline (5;12;25;26;95)<sup>1</sup>, particularly for the most

vulnerable and deprived as they are more likely to be affected and to rely on social protection and public services. The UK government's austerity programme to reduce the country's deficit includes spending cuts in areas such as welfare, local authority budgets and public sector pay. The £18 billion savings made by a series of welfare reforms will be considered by this report; they will have the greatest impact on the most deprived as those are the individuals who rely most heavily on benefits (96). See Appendix 1 for an overview of the main welfare changes. The Chancellor of the Exchequer in his March 2012 budget suggested that a further £10 billion in welfare savings may need to be made by 2016, though the detail is as yet unknown (27).

#### The health effects of economic crises and rising unemployment

Studies looking at the population effects of macro-economic conditions on health have tended to consider either times of recession compared with non-recession, or the impact of an increase in the unemployment rate.

#### Mortality

Studies into the short-term health effects of the current and other economic downturns and rising unemployment rates on populations have not always produced consistent findings. Many studies have looked at overall mortality and while some suggest that mortality increases in times of economic decline, others find that a deteriorating economic situation is associated with short-term neutral or reduced mortality rates.

The Great Depression of the 1930s is commonly referred to as a period when recession appeared to reduce mortality: mortality rates in American cities fell by about 10 per cent across the whole population during that time (26). Tapia-Ganados and Diez Roux found that mortality fell and life expectancy increased for almost all demographic groups in the United States during all four years of the Great Depression (1930–33), whereas mortality tended to peak under economic expansion (6). Ruhm studied 50 US states between 1972 and 1991 and found that a rise in the unemployment rate was associated with a short-term fall in overall mortality (except suicides), particularly for young adults, in relation to preventable causes of death such as road traffic accidents, cardiovascular and liver disease, influenza and pneumonia (7). Further study by Ruhm found that

a 1 per cent rise in employment was associated with an increase of 0.75 per cent in deaths from coronary heart disease between 1979 and 1988 (again in the USA) (97). From these studies it appeared that economic decline and higher unemployment had a positive impact on mortality, at least in the short term.

However, other studies have found that mortality rates fall in times of economic decline. An analysis of panel data from Brazilian states between 1981 and 2002 indicated that the overall mortality rate was higher during economic recession and that as macro-economic conditions improved, increasing employment rates, mortality rates decreased (98). A study of four economic crises in Mexico during the 1980s and 90s found that mortality rates for the elderly and very young increased (or declined less rapidly) in crisis years as compared to non-crisis years (99).

Thus there does not appear to be a 'typical' mortality response to recession. While some causes of mortality will increase, others will fall and the impacts these will have on overall mortality will differ between populations. For example, fewer road traffic fatalities (probably due to lower incomes leading to less car use) are commonly associated with economic decline, while suicide rates tend to increase (4;12). Further, each crisis and the population it affects will have different characteristics – in particular, government responses to economic problems as well as their existing systems will have a significant influence on many causes of mortality. Without looking at the individual effects, it is difficult to know whether the results are mediated through individual unemployment or reduced public spending, for example. Whether the overall mortality rates rise or fall in London, however, is not the only or prime concern, as overall mortality rates do not take into account specific health outcomes, the longer-term impacts, morbidity trends or the health inequalities impacts (5–7).

### Health inequalities

Research suggests that inequalities in health according to socioeconomic status, level of education and geographical area are likely to widen following an economic crisis. Socioeconomic inequalities in self-rated health widened during the 1990s recession according to one repeated cross-sectional survey among working age people in Japan (22). Research into mortality in the United States in the 1980s and 90s found that the health of those with a high school degree or higher level of education, tended to improve during economic recessions, while those with very low education were at greater risk of worse health during these times (23). UK research has shown that in the short-term, inequalities in mortality between areas increased following the 1929–33 economic crash (24).

Those worst affected are likely to include people on low incomes, groups particularly vulnerable to unemployment (see page 21), or those who do not have the material or psychosocial resilience to deal with the problems caused by an economic crisis (13). Different age groups are likely to be affected in different ways (100). For example, in Canada,

mortality patterns in times of recession were found to be more significant for adults in their thirties than for infants and older people (101). Men have been shown to be at increased risk of mental health problems and death due to suicide or alcohol use during times of economic difficulty (10).

### Cause-specific mortality

In relation to specific causes of mortality, Stuckler *et al* looked at data from 26 EU countries from 1970–2007 and found that every 1 per cent increase in unemployment was associated with a 0.79 per cent rise in suicides among people under 65, a 0.79 per cent increase in homicides, and a 1.39 per cent decrease in road traffic deaths, demonstrating how significant the overall mortality effects can be even if there appears to be little alteration in the overall mortality rate (4). They identified a similar pattern in Europe during the recent recession between 2007–09, though there were substantial differences between countries likely to be due in part to differences in social protection (5). The suicide rate increased by at least 5 per cent in all of the 10 countries studied except for Austria, where the suicide rate fell by 5 per cent. The countries facing the most severe financial crises, such as Greece and Ireland, had greater rises in suicides (17 per cent and 13 per cent respectively) than most of the other countries (5).

### Suicide and mental health impacts

Other studies have consistently found that suicides tend to occur more in a shrinking economy (5–7). Chang *et al* showed an increase in suicides of almost 45 per cent in some Asian countries following the 1998 financial crisis (8). Luo *et al* found that the overall suicide rate generally rose during recessions and fell during expansions in the United States over the period 1928 to 2007, though different age groups responded differently (9). This demonstrates an immediate and severe impact of economic decline on mental health and wellbeing, which has been reflected consistently in research (13;14).

In fact, some studies have concluded that mental health deteriorates more than physical health during tough economic times (15;16). Economic crisis increases the risk factors for poor mental health, such as low household income, debt and financial difficulties, housing payment problems, poverty, unemployment and job insecurity (5;10;102–104). The current economic crisis may have contributed to an increase in depression among populations: a Canadian study found a higher prevalence of major depressive disorder and reported dysthymia (less severe depressive disorder) in the population over the period January 2008 to October 2009 than previously (17); in Hong Kong, cross-sectional surveys were conducted in early 2007 and again in mid-2009, showing a significant increase in prevalence of a major depressive episode (18). Wellbeing has been found to be negatively affected by an increase in the average state employment rate, with a recent US study suggesting that an increase in the average rate worsens an individual's 'health-related quality of life'<sup>2</sup> (16).

Evidence from UK charity Mind indicates that mental health may have suffered in the economic downturn, with a 100 per cent increase on calls to its Infoline and Legal line on both personal finances and employment since the start of the recession (88). A report based on GP experiences in deprived areas documented concern regarding the number of patients with deteriorating mental health (89). The report noted that this was influencing people in work who were under more stress due to increased work load and job insecurity, and those with chronic mental health issues who have had their benefits cut and are struggling to make ends meet, have increasing contact with GPs and Psychiatric services, more anti-depressant and antipsychotic use and increasing self medication with drugs and alcohol (89). London already has significantly higher rates of serious mental health disorders and people detained under the Mental Health Act compared with the UK average, including significant variations in different conditions between, for example, different boroughs or ethnicities (105).

### Violence

The aforementioned increase in homicides indicates that violence might increase during recession. This is supported by a WHO report that suggests that the strain on families caused by a recession might increase family violence and child neglect (10). Reports of increased domestic violence and relationship breakdown have been made in the current downturn, with associated impacts on child wellbeing (11). This may exacerbate the already disproportionately high rate of violent crime in London, which already stands at a fifth of all crimes against the person in England and Wales (106), including almost half of all teenage murders in England (107).

### Infectious disease

A systematic literature review by Suhrcke *et al* found that 30 out of 37 studies from developed countries<sup>3</sup> gave evidence of worse (as opposed to neutral or improved) infectious disease outcomes following periods of economic crisis (19). They attributed this primarily to higher rates of infectious contact in poorer living circumstances, worse access to therapy, poorer retention in treatment or potentially to reduced immunity due to lower living standards or living with higher stress levels (19). The type of infectious diseases that increase are likely to differ according to existing disease prevalence within a country, though there is evidence that tuberculosis (TB) and HIV are among those that have been impacted in the past. London has the highest TB rate of any capital city in Western Europe, with 21 boroughs rated 'high'<sup>4</sup> by the WHO in the past 5 years (108), as well as a rate of HIV three times higher than the rest of the country, and as much as five times higher in some boroughs (105). Particular groups within the population including children, old people, migrants, homeless people and prisoners are more vulnerable to infectious disease (19).

### Longer-term health impacts

There is comparatively little research into the longer-term health impacts of an economic crisis. One study of mortality over almost 200 years in Holland showed that being born during a recession increases risk of mortality in later life, and disproportionately so for the lower classes (20). An analysis of the relationship between trends in economic indices and mortality rates in England and Wales for the period 1936–76 found that cardiovascular mortality began to increase two to three years after increased unemployment, with the effect persisting for 10 to 15 years (21). Evidence of negative long-term individual health impacts of unemployment is described on page 22 and supports these findings.

## Key points

- The 2008/09 recession in the UK has been followed by a slow and uncertain recovery, with unemployment in London rising from 6.7 per cent in the second quarter of 2008 to 10.1 per cent in the first quarter of 2012.
- An economic crisis has a huge impact on the social determinants of health, though the distribution of harm is likely to affect some more than others.
- Evidence suggests that inequalities in health according to socioeconomic group, level of educational attainment and geographical area are likely to widen following an economic crisis.
- Evidence from previous economic downturns indicates health impacts that might be anticipated in London:
  - An increase in suicides and parasuicides; possible increases in homicides and domestic violence
  - Fewer road traffic fatalities
  - An increase in mental health problems, including depression, and possibly lower levels of wellbeing
  - Worse infectious disease outcomes such as tuberculosis and HIV
  - The longer-term health impacts are likely to be negative given the poor long-term individual health impacts on individuals of unemployment and stress. There is evidence of negative medium- and long-term impacts of an economic downturn on overall and cardiovascular mortality.
- Government policies, institutions and the extent of social protection will play a substantial role in exacerbating or mitigating the negative health and inequality impacts of economic decline, particularly for the most vulnerable.

## 3

# The employment and health impacts in London as a result of the economic downturn and welfare reforms

### Differences in employment by population group

Particular groups within the population are more vulnerable to becoming unemployed during the economic downturn, which means they will face a higher risk of poor health outcomes. Employees of certain sectors will be more affected than others depending on structural factors associated with the particular economic situation. Brenner's study of England and Wales over the period 1936–76 concluded that people in occupations providing non-essential goods and services, and the less skilled, are particularly vulnerable in recessions (21). Those more vulnerable to unemployment generally may be at greater risk, including people with fewer skills, lone parents, those with mental health problems and chronically ill or disabled people (21). Not only are these individuals more vulnerable to unemployment and poor health, but they are also less likely to have the material or psychosocial resources to deal effectively with the negative effects (109).

Research into previous recessions provides some suggestions as to which population groups may be most affected by an increase in unemployment. Men have tended to suffer the effects of unemployment more badly overall than women, though the increasing number of women in the labour market and changes to women's drinking patterns in the UK might suggest that such gender differences are no longer as relevant (15). It is likely that the effects differ between men and women according to job sector: a review conducted for the Equality and Human Rights Commission (EHRC) looked at previous recessions in the UK and found that women were more likely to be employed in less cyclically sensitive jobs and therefore men's unemployment rose faster, yet where women were employed in traditionally male-dominated sectors they were the first to lose their jobs (11). The same review found evidence that young people and older people were most affected by an increase in unemployment: young people have difficulty entering the labour market and are more likely to lose jobs if they have them, and older people are encouraged to take early retirement (11).

It is too early to make definitive judgements about which groups have been worst affected during the recent economic crisis, though initial analysis by the National Equality Panel comparing employment in the second quarters of 2008 and 2009 in the UK suggests that nationally, young people aged 18–24 have been the worst affected, while men were worse affected than women, and disabled people and those

from minority ethnic groups taken as a whole have been less affected than the national average (though there is evidence that black ethnic groups have been worse affected) (34). Analysis by the IFS of UK employment levels between 2007 and 2010 indicates similar patterns: employment fell more for young people under 25, for men more than women and for lower education groups (35). The employment rate of those above pension age actually increased over this period, though from a relatively low base (35). These differential impacts of unemployment will likely widen health inequalities between different groups, as those who become unemployed suffer worse health outcomes. Given that those lower down the socioeconomic scale are more vulnerable to both unemployment and its health effects as mentioned previously, and those groups identified as most vulnerable are more likely to be of low socioeconomic status, socioeconomic health inequalities are also likely to increase.

### Health impacts of employment

#### Unemployment and health

Although it is unclear how an increased unemployment rate affects the mortality rate in the short term, evidence suggests that it has a negative impact on the longer-term mortality rate, as well as both negative and positive impacts on a variety of population health outcomes (see Chapter 2).

This section identifies the health impacts of unemployment at an individual level and shows that unemployed people are more likely to suffer poor physical and mental health compared with those in employment. Figure 3 shows the social gradient in the subsequent mortality of those that experienced unemployment during the dramatic increase in the early 1980s. For each occupational class across the social gradient, the unemployed have higher mortality than the employed (3;110). Some of the factors that contribute to this are discussed below.

Research has shown that unemployed people are more likely to suffer from limiting long-term illness, mental illness, cardiovascular disease and overall mortality (3;111). They have much higher use of medication and worse prognosis and recovery rates (3;111). Evidence suggests there is an association between job loss and symptoms (though not clinical diagnoses) of depression and anxiety (112). The negative health impacts of unemployment tend to be greatest among the long-term unemployed (28).

Unemployment has material and psychosocial effects on mortality and morbidity. Firstly, a reduction in income may cause financial problems and lower living standards, depriving a household of the material possessions necessary to lead a healthy life (3). Secondly, unemployment, or fear of unemployment, can act as a stressor, triggering distress, anxiety, depression, and/or leading to worsening physical health (3;25;26;37). Loss of work results in the loss of a core role, linked to one's sense of identity (28) and may reduce social integration and lower self-esteem. Being unemployed might deprive an individual of the feeling of control over their life that is an essential protective feature of good health (3;37). Finally, unemployment impacts on healthy behaviours. It is associated with increased smoking and alcohol consumption and decreased physical exercise (3;15).

#### Long-term effects of unemployment

The health and social impacts of unemployment on an individual can be long-term, lasting beyond their period of unemployment. Evidence from Sweden shows that men and women who became unemployed when their workplace closed down had a 22 per cent and 44 per cent (respectively) increased risk of alcohol-related hospitalisation over a subsequent 12-month period (29). In the UK in the 1990s about 40 per cent of individuals who lost their jobs reported financial difficulties for one to two years and 24 per cent reported difficulties for three to six years after becoming unemployed (30).

Additionally, unemployment early on in a career has been shown to have lasting negative effects on later employment (37), which should deepen concern over the high youth unemployment rate in London. Department for Education analysis has recently shown that people who are 'not in employment, education or training' (NEET) on leaving school have a very high risk of remaining unemployed in the medium term (five years) and have a greater risk than their peers of unemployment and lower wages in the long term (up to 10 years on) (38).

#### Effects of unemployment on those who are not unemployed

A higher unemployment rate has also been shown to negatively affect the self-reported health of young individuals who had not experienced unemployment (39). Though this study looks at the population rather than the individual effects, it suggests that other mediating factors aside from unemployment are likely to influence health during times of economic hardship, and these may include pessimism about the future, high demands at work<sup>9</sup>, financial problems and lack of control over the work situation – it appears that many of these factors are to some extent related to employment (39).

Families and communities might also experience poorer health as a result of financial problems or psychosocial stressors caused by an individual's unemployment (3;15). Research indicates that the wellbeing of spouses and children might be negatively

affected (113), such as a study that showed a negative effect of husbands' job stressors on the mental health of their wives (114).

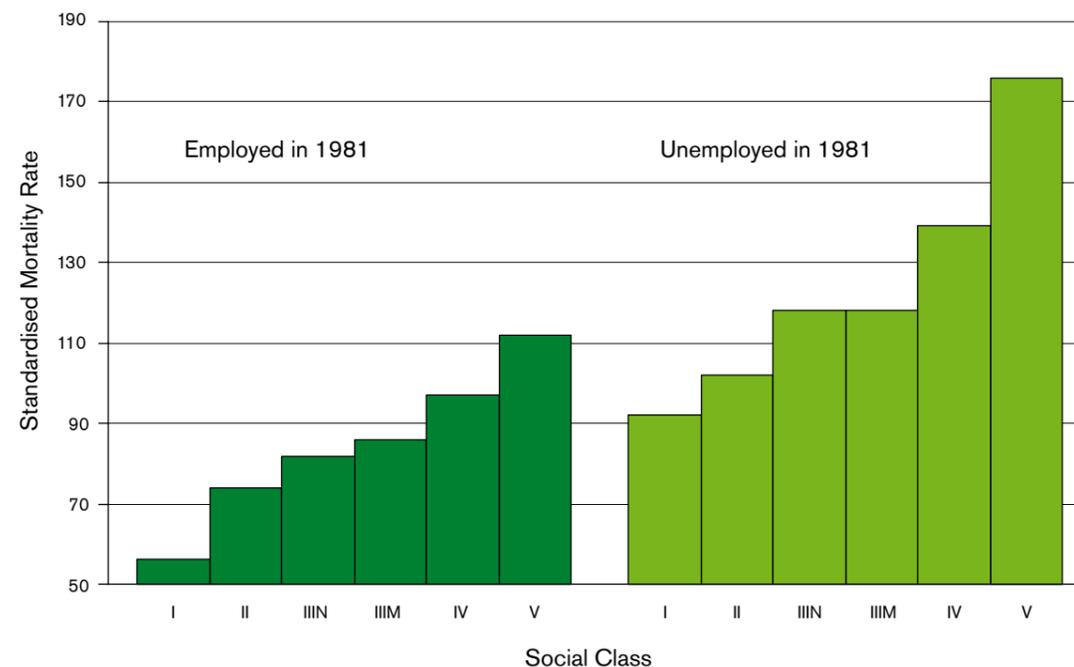
#### Working conditions

Job security and a sense of control at work are protective of good mental health (10). Individuals who remain in the workplace during an economic downturn may be subject to more psychosocial stress from increased uncertainties surrounding job security and likelihood of redundancy (15) and increased competition for jobs may drive down wages and working conditions. Recessions have coincided with higher levels of work-related disability, especially related to mental health problems (11). The ESRC has suggested that employers are less likely to prioritise work-life balance, flexible working and diversity initiatives during the current economic downturn and it is concerned that the fall in equal pay and sex discrimination claims made by women reflects their fear of job loss (11). This is important because being in work is mainly protective when it is 'good' work. "Being without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill"(3).

#### Key points

- Particular groups are more vulnerable to unemployment than others, and initial analysis of the current downturn across the UK suggests that young people (under 25), men, those with lower-level skills or education and employees of certain sectors have been disproportionately affected by unemployment.
- Unemployed individuals, particularly the long-term unemployed, have a higher risk of poor physical and mental health compared with those in employment.
- Unemployment, or fear of unemployment, can act as a stressor, lead to lower living standards or the loss of a core role, identity, feeling of control or self-esteem, can reduce social integration and can increase unhealthy behaviours such as smoking and alcohol misuse.
- The health and social effects resulting from a long period of unemployment, such as alcohol-related hospitalisation or financial difficulties, can be long-lasting.
- Early unemployment often has a significant effect on later employment opportunities.
- Worse self-rated health has been reported by those in employment during an economic downturn as well – perhaps due to their pessimism about the future, high demands at work, financial problems and lack of control over the work situation.
- Families and communities might also experience poorer health as a result of financial problems or psychosocial stressors caused by an individual's unemployment.
- Being in work is mainly protective when it is good quality work. However, those in employment during an economic crisis may be subject to more psychosocial stress from increased uncertainties surrounding job security and likelihood of redundancy. Increased competition for jobs may drive down wages and worsen conditions.

**Figure 3** Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 census



Source: Office for National Statistics Longitudinal Study (110)

### The employment effects of the economic downturn in London

A rise in unemployment and involuntary job losses are more common during times of economic contraction than in periods of expansion. The unemployment rate in London increased from 6.7 per cent in the second quarter of 2008 to 10.1 per cent in the first quarter of 2012 (31;32). There is predicted to be only a slow increase in employment in London during 2010–20, of 315,000 (33). The unemployment rate is highest in Inner East and South London, yet the increases during 2007–10 have been greatest in East and Outer London (115). Unemployment increased by about 50 per cent in Outer London over the period, yet by only 25 per cent in Inner London, reducing the disparity between the two (115). Inner West London has seen the smallest increases in unemployment (115).

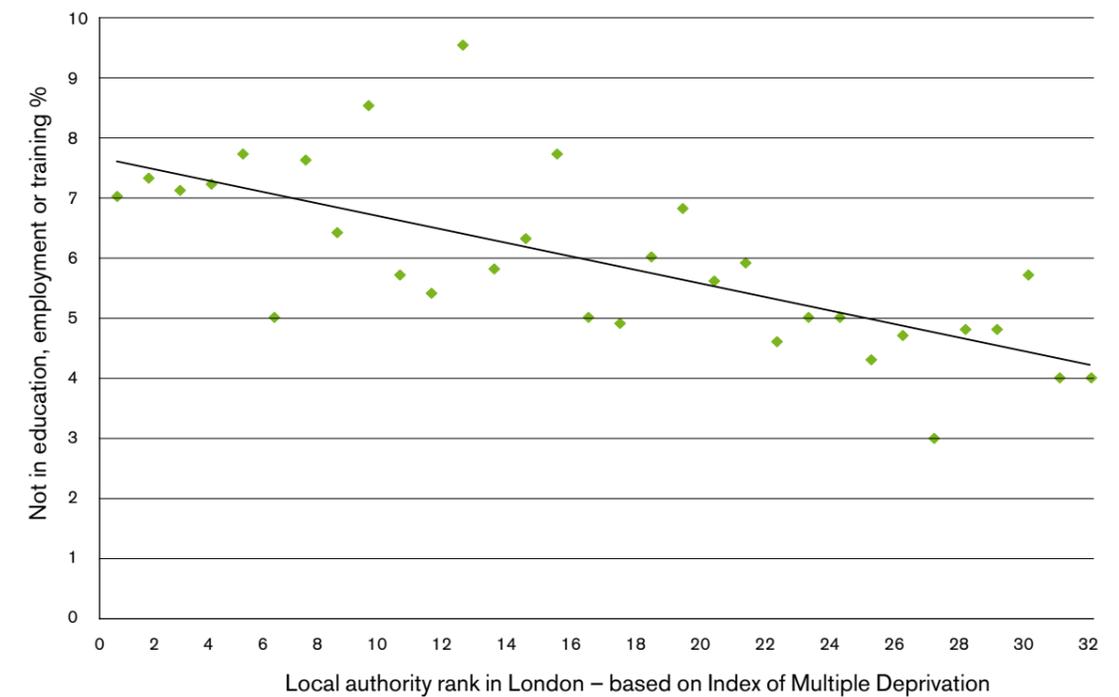
The unemployment rate is known to differ substantially between different industrial sectors and types of occupation, though routine data on this is not currently available for London. Nationally, there has been a reduction in the number of working hours among those who remain in employment, with a 1 per cent fall on average over the course of the 2008–09 recession and a further 1 per cent fall by the end of 2010 (35). This trend indicates that under-employment is an issue across the UK.

A third of London's unemployed population are under 25 years old (115). In the second quarter of 2011, 16.2 per cent of England's 16–24 year olds were NEET, up from 13.6 per cent in the first quarter of 2008. Although the figures for the South-East and West of London are about the same as the figure for England (and South-West London less at about 14 per cent), East London has 18–20 per cent NEET and the rate for North-East London is much higher with over 20 per cent NEET (36). Figure 4 shows the percentage of the population of 16–19 year olds (note the different age range to previous NEET figures) in each borough that are NEET, ordered by rank on the Index of Multiple Deprivation. It confirms that there is considerable variation across London and shows that more deprived areas have a higher proportion of NEETs than less deprived areas. These figures are particularly concerning because of the high number of young people in London and because of the worse long-term employment prospects of those who are NEET on leaving school (see page 22).

### Key points

- The economic crisis has caused the unemployment rate in London to increase dramatically to 10.1 per cent in the first quarter of 2012 and the recovery is expected to be slow. The increase was highest in East and Outer London. The unemployment rate is known to differ between sectors and occupations.
- Nationally, there has been a reduction in the number of working hours among those who remain in employment, suggesting that there may be a rise in under-employment across the UK.
- The proportion of 16–24 years olds who were not in employment, education or training (NEET) increased across the UK between 2008 and 2011. More deprived areas of London have higher proportions of young people who are NEET; for example, in East London 18–20 per cent of 16–24 year olds are NEET, and the rate for North-East London is over 20 per cent.

**Figure 4** The proportion of young people aged 16–19 not in employment, education or training (NEET) in each London borough between Nov 2010–Jan 2011, ordered by rank on the Index of Multiple Deprivation (1)



Source: Department for Education (1)

### The employment effects of the welfare reforms

A key stated aim of government reforms to the benefit system is to incentivise people to take up work, through ensuring that people are better off in employment than on benefits. It would be useful to monitor the extent to which these incentives work, to aid future policy decisions. There are two important conditions for the success of this policy: firstly the incentives and sanctions need to be sufficient, and secondly there must be jobs available. It is also necessary to have programmes which help people move into good quality work, particularly people furthest from the labour market.

#### Incentives and sanctions

Whether or not the reforms provide the necessary financial incentives (including benefits and tax credits) to ensure people are better off in work is disputed. There will be lower out-of-work payments for everyone compared to current levels, which should strengthen work incentives.

Marginal Effective Tax Rates (METRs) give the proportion of a small increase in earnings that is lost in either higher taxes or lower benefit entitlements. These are predicted to increase for most groups following the 2011/12 tax and benefit reforms (weakening incentives for those in work to slightly increase their hours or earnings), be relatively unaffected by the 2012/13 and 2013/14 reforms and fall significantly for lone parents and single-earner couple

households with children following the introduction of Universal Credit (40). London households will have lower gains and therefore weaker incentives than the rest of England to move from unemployment into low-paid work because of the higher cost of working (due to higher childcare and transport costs, for example) (57).

There have also been reforms to sanctions and conditionality measures which are intended to improve compliance and contribute to getting people into work (see Appendix 1 for an outline) (116). This includes reforming benefit sanctions to encourage compliance, moving lone parents with a child aged over five onto Job Seeker's Allowance (JSA) or Employment and Support Allowance (ESA) where they are expected to actively seek work, and introducing the claimant commitment which sets out a claimant's responsibilities in return for benefit payments (116).

The introduction of Universal Credit is expected to integrate and simplify the benefits system. This has the potential to incentivise people to move into employment, as they are less likely to worry that moving into work will cause administrative problems with their benefits. Further, it may avoid relatively common misunderstandings that certain benefits (such as Housing Benefit and council tax benefit) cannot be claimed while in work (117), which may strengthen work incentives.

Different households and individuals will be incentivised financially or affected by conditionality

and sanctions in different ways following the reforms. For example, the IFS has shown that tax and benefit changes<sup>6</sup> introduced in 2011/12 on average weaken incentives for those with children to undertake paid work, but strengthen incentives for those without children (40). Welfare reforms such as reducing the proportion of childcare costs paid through tax credits make it less financially viable for lone parents and second earners in couples to work and are therefore unlikely to enhance the employment prospects of women (118). Increasing restrictions on lone parent benefits may impact on women in the opposite way, forcing more women to work, given that 96 per cent of lone parents on Income Support (IS) with a child aged five to six are female (119).

#### Availability of employment

Strengthening financial incentives can do little if there are not enough jobs. The average ratio of JSA claimants to JobCentre Plus (JCP) vacancies in London was 9:1 in July 2011, and 6:1 for Britain as a whole (120). Some of the highest ratios in the country were in the most deprived London boroughs, including Haringey (29:1), Waltham Forest (25:1), Hackney (22:1) and Lewisham (21:1) (120). However, areas of the City and West London were doing much better than the rest of the country with ratios of 3:1 in Kingston-upon-Thames and Westminster, for example. (120). Between July 2010–11, about half of London’s boroughs saw the ratio of unemployed to job vacancies increase, particularly in the East, such as Waltham Forest, with an increase of 14.5 per cent (120).

Many jobs are not advertised through JCP so the data should only be viewed as indicative of the employment environment. Further, people in London frequently travel across borough boundaries to get to work and therefore borough-level statistics of this type may be misleading. However, it is those on low incomes who may find it more difficult to travel long distances to get to work and therefore for whom local job vacancy rates are more significant. The data suggests that there may not be enough jobs in London for the number of people searching, and that this problem is more acute than for the rest of the country. This is likely to undermine incentives to take up work for many individuals, though the lack of employment opportunities is unlikely to remain a problem in the long term.

#### Work Programme

Another aspect of the welfare reforms is the new Work Programme, which the government has introduced to help unemployed people find work. Payments for the selected providers of unemployment support will be based largely on results rather than made upfront, and payments will be higher for getting people into sustained employment and for ‘hard-to-reach’ groups. The government should ensure that the programme works to sustain people in work rather than just getting them into work in the first place and that it maintains a focus on working with those furthest from the labour market. Integrating employment support within London’s

Improving Access to Psychological Therapies (IAPT) programme is an example of cross-sector working to achieve positive outcomes for people affected by common mental health problems (121). This includes an emphasis on support to sustain employment as well as to move into work or education/training, and generated £2.79 in reduced costs for every £1 spent (121). Concerns have been raised about the Work Programme’s lack of voluntary sector involvement and about the system’s ability to help those furthest from the labour market (122), though not enough is yet known to make a reasonable judgement over whether it will be more successful than previous initiatives at finding work for the unemployed. Further, policies to get people into work are not sufficient for optimal minimisation of health inequalities because that work needs to be good quality.

#### Key points

- The welfare reforms are intended to ensure everyone is better off in work than on benefits. Their success is conditional on effective incentives and sanctions, sufficient enough jobs being available and programmes to help those who need it to move into work.
- It is unclear whether or not the reforms provide effective financial incentives and/or sanctions and conditionalities to encourage more people to take up work, though it appears that different groups are affected in different ways.
- Universal Credit should simplify the benefits system, which may strengthen work incentives.
- Incentives to work will be far less effective if there is an insufficient number of jobs available and data indicates there are not currently enough jobs in London for the number of people searching.
- The government’s new Work Programme is intended to help people find work. It is important that the focus is on sustaining people in good quality work and working effectively with vulnerable people and those furthest from the labour market.

## 4

# The income and health impacts in London as a result of the economic downturn and welfare reforms

#### Health impacts of income

The level of household income and wealth affects household health. Figures 1(a) and (b) in the Introduction show that more deprived areas (based on the Index of Multiple Deprivation (IMD) which includes income as one of its indicators) have higher mortality rates, and a similar relationship can be seen between deprivation, income and other health outcomes. Households living on a low income may find themselves with insufficient resources to lead a healthy life, which manifests itself in a number of different ways. They might be unable to afford goods and services that improve their health, such as fuel for their home or nutritious foods, or they might be forced to reduce their leisure time and be prevented from having a social life, leaving them feeling excluded from society, which has significant mental and physical health impacts (3).

#### Mental health impacts

Those households living in poverty are therefore likely to have worse health outcomes than those who are not. Indeed, poverty is associated with worse mental health outcomes (including sleep deprivation and depression among new mothers) (45). This is particularly the case for women because they are more likely than men to handle family budgets, have caring responsibilities and are often the ‘shock absorbers’ of reduced family incomes, meaning that they ‘go without’ to protect their children from the worst effects of poverty (44;45).

A study of UK households showed that those on low incomes are more likely to have a mental disorder, but that this effect appears to be largely mediated by debt (46). Studies show that households in debt or facing financial difficulties or housing payment problems suffer worse mental health including an increased likelihood of having a mental disorder (3;103). Debt has commonly been associated with increased stress, stigma, shame and relationship problems with partners and children (45;123). It should be noted that the causal pathway may work both ways: those with a pre-existing mental health problem are more likely to get into debt (124).

#### Child poverty

Particular emphasis should be given to poverty in households with children, because of the impact of child poverty on the health and development of a child (41). The UK is bottom of UNICEF’s 21-country child well-being study (125) and London

performs worse on almost all child well-being metrics including child obesity and low birth weight babies (105;126;127). This emphasises the importance of improving the early years for Londoners.

Children born into poverty suffer an increased risk of mortality in the first year of life and in adulthood; they are more likely to be born early and small; and they face more health problems in later life (42). Children from disadvantaged backgrounds are more likely to start primary school with lesser personal, social and emotional development and have significantly increased risk of developing behaviour disorders, all of which can hinder educational attainment, and cause difficulties in relationships and to mental health throughout the life-course (3). A Finnish study showed an increase in child mental ill-health associated with a reduction in family income, attributed to increased economic pressure and negative changes to parental mental health, marital interaction and parenting quality (43).

#### Minimum income for healthy living

However, there are households above the poverty line also living with insufficient income to sustain a healthy lifestyle. This gave rise to the Marmot Review’s recommendation to establish a minimum income for healthy living (MIHL) which includes being able to pay for “needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene” (3). Households receiving less than this amount are likely to suffer poorer health outcomes than those on higher incomes, illustrating the impact of income on health.

Inequalities in income are also related to health. Evidence suggests that the more unequal a society, the worse the health and other social outcomes for the whole population (128).

## Key points

- The level of household income and wealth affects household health. Households living on a low income may find themselves with insufficient resources to lead a healthy life.
- Living in poverty is associated with worse mental health outcomes, particularly among women, though the relationship may be largely mediated by debt – a further determinant of poor mental health.
- Children born into poverty have increased risks of physical and mental health, developmental and social problems, both immediately and throughout their life-course.
- A minimum income for healthy living includes being able to pay for ‘needs relating to nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene’. Households living below this amount are likely to suffer poorer health outcomes than those on higher incomes.

## Minimum income standards

- **Minimum Income for Healthy Living**  
Research evidence and government recommendations set out what is required to live a healthy life. For example in relation to a healthy diet, physical activity, housing, psychosocial interactions, transport, medical care and hygiene. The Minimum Income for Healthy Living approach attaches a cost to meeting these recommendations, for different types of people (129;130).
- **Minimum Income Standard**  
The Minimum Income Standard, developed by the Joseph Rowntree Foundation, is a similar calculation to the MIHL, attaching a cost to purchasing sufficient ‘resources to participate in society and to maintain human dignity, consuming those goods and services regarded as essential in Britain’ (131). The approach differs in that those goods that are deemed essential are based on discussions with members of the public and experts.
- **London Living Wage**  
The London Living Wage is an hourly rate to indicate the minimum wage an employee in London should be paid. It is calculated each year by the Greater London Authority and considers both the average income needed to achieve a minimum income standard and the 60% medium income level in London (55).

## Higher living costs in London

- Childcare is 23 per cent more expensive than the England average (57).
- Housing costs are more than 50 per cent higher than the England average (57;84).
- Transport is 63 per cent more expensive than other metropolitan areas (57).

## The income effects of the economic downturn in London

The recent economic crisis has resulted in rising unemployment, along with constricted social spending (including on social protection) and higher levels of inflation than income growth. Increasing unemployment and reduced social spending are likely to lead to a fall in income and wealth for many London households until (and after) the economy recovers (77). Across the UK, average incomes actually increased during the 2008–09 recession, though appeared to fall substantially during 2010/11, demonstrating a short delay in income effects (35). For those of working age, household income is generally made up of wages from employment minus taxation, and/or benefits provided by the state. Therefore, wages, taxation and benefit policies are key factors to consider when thinking about a minimum income necessary for healthy living. The other factor to consider is outgoings – particularly relevant for London which has a higher cost of living than elsewhere in the UK.

The average income is higher in London than the rest of the UK, yet it drops to about equal to the national median once regional price variation has been taken into account (47;48). Income inequalities are far wider than in the rest of the country, with the poorest 50 per cent having only 15 per cent of total income in Inner London and 20 per cent in Outer London, compared to 25 per cent in the rest of England (49). In 2005–08, 53 per cent of Londoners lived in households with a weekly income below a minimum income for acceptable standard of living<sup>7</sup> – a calculation by the London Health Commission based on a similar concept to the MIHL – rising to 82 per cent for the Pakistani and Bangladeshi populations and 85 per cent for lone parents (51).

There is no evidence to suggest that this or other recessions has or will necessarily lead to widening income inequalities if they are based on the difference in incomes between the top and bottom 10 per cent, because the incomes of those at the bottom have no further to fall. During 2007–09, income changes across the UK were relatively progressive, with the bottom catching up slightly with the top and middle (35). However, the IFS predicts that child and working-age poverty across the UK will increase over the next decade (52). They suggest that the number of children in relative poverty is set to increase nationally between 2010/11 and 2015/16 by around 400,000 (from 19.4 per cent to 22.3 per cent of the child population) and those in absolute poverty by about 500,000 (from 19.4 per cent to 23.1 per cent of the child population) (40)<sup>8</sup>.

London has the highest rates of child (39 per cent), working-age (25 per cent) and pensioner (23 per cent) poverty in England (58). Many in-work London households are living in poverty (41): just over half of children and working-age adults in poverty in London live in working families (58). This is a problem across the UK, yet those affected in London face a lower standard of living because of the higher costs of living (particularly housing) compared with the rest of the country.

For those in paid employment, receiving a living wage will increase the chances of their household remaining above the poverty threshold and achieving the MIHL. In London the Greater London Authority (GLA) calculated a minimum hourly rate of £8.30 as the London Living Wage (LLW). The LLW is calculated each year and has been implemented across more than 100 London-based organisations. The LLW takes account of both the average income needed to achieve a minimum income standard and what constitutes 60 per cent of median income in London (55). For a particular household, achieving either standard depends on more than an individual’s hourly rate – it is also affected, for example, by household composition, number of earners and their hours worked. Whether earned income translates into a minimum standard of healthy living for the household will also depend on taxes paid and benefit entitlements across the household.

Debt problems are a reality for many Londoners. In the capital, 9 per cent of households are in arrears with at least one domestic bill – a higher figure compared with other UK regions apart from the North West – and according to data from Citizen’s Advice, more clients sought their advice for credit card or personal loan debt in 2010 than for debts associated with bills and utilities, indicating that these problems may also be significant (53). Overall levels of debt across the UK have remained high but have not increased since 2008, with banks and lenders unwilling to lend as much and people trying to pay off debts rather than take out new ones (53). However, the number of people seeking debt advice appears to have increased, according to debt advice services, which may suggest an increase in number, severity or perception of debt problems (54;91;132).

There is some anecdotal evidence of increasing financial hardship in the UK. A recent report based on GP experiences in deprived areas documented practices reporting cases of an elderly patient going to a friend’s house in order to wash; families relying on relatives to pay for food and cigarettes (unable to stop smoking due to stress); and a mother resorting to prostitution to feed herself and her family (89). Camila Batmanghelidjh, founder and chief executive of Kids Company, said: “The number of children coming to us with hunger problems has increased five-fold in a decade and the number of children self-referring on a daily basis has doubled in the last year” (90).

Women are likely to be harder hit as within a couple they are more likely to be responsible for managing debt (45), though the Consumer Credit Counselling Service has reported a substantial increase in the number of men seeking debt advice in England. This number increased by 51 per cent from 2007–10, while it only increased for women by half this much (54). There is also evidence of variability in London, with some areas more affected than others. One borough-level indicator of households struggling with debt is the rate of landlord repossession, which is higher in London than elsewhere in

the country (115). Landlord repossessions are more concentrated in Outer London, particularly in the North and East. There has been little change since 2007/08, though some areas such as Redbridge (the London borough with the highest rate of landlord repossession orders) have seen a slight increase (133).

### Key points

- The recent economic crisis has resulted in rising unemployment, along with constricted social spending (including on social protection) and higher levels of inflation than income growth. This is likely to lead to a fall in income for many Londoners.
- London has a much higher cost of living than the rest of the UK. The average income is higher, yet it drops to the national average once regional price variations are considered. Further, income inequalities are far wider than in the rest of the country, though it is unlikely they have increased during the economic downturn.
- More than half of Londoners live in households with a weekly income below the minimum for an acceptable standard of living and this increases to more than 80 per cent for groups such as the Bangladeshi and Pakistani populations and lone parents.
- London has the highest poverty rates in England and the IFS predicts that child and working-age poverty will increase across the UK over the next decade.
- Many of those in poverty live in working families. Receiving a living wage will support the chances of an in-work household remaining above the poverty threshold and achieving the Minimum Income for Healthy Living. The London Living Wage takes account of both the average income needed to achieve a minimum income standard and what constitutes 60 per cent of median income in London. For a particular household, achieving either standard depends on more than an individual's hourly rate – it is also affected, for example, by household composition, number of earners and their hours worked.
- There are many London households in debt, with 9 per cent in arrears with at least one domestic bill. Though overall levels of debt in the UK have not increased since 2008, the number of people seeking debt advice appears to have increased.
- Landlord repossessions (an indicator of households struggling with debt) shows variability across London, with higher rates in Outer London, particularly in the North and East.

### The income effects of the welfare reforms

Many elements of the changes to the welfare system will mean that households are financially worse off and will need to live on a lower income. Furthermore, earnings have not kept pace with inflation since 2010.

The main benefits are now uprated by the Consumer Price Index (CPI) rather than the Retail Price Index (RPI). Both are measures of inflation, but the CPI excludes the costs of mortgage interest payments, rents and council tax and gives, on average, a 0.7 per cent lower measure of inflation (62;134). Changes to the tax credit system reduce the amount of tax credits that in-work households receive and increase the number of hours they must work to qualify. Those in receipt of disability benefits are being reassessed and moved onto new benefits with stricter requirements, while Local Housing Allowance (LHA) is undergoing dramatic reform and will, overall, reduce the amount that people on benefits receive to cover their housing costs.

A household benefit cap is to be introduced which sets a maximum amount that a workless household can receive in total benefits. The Department for Work and Pensions (DWP) predicts that 67,000 households will have their benefits reduced by this policy in 2013/14 and 75,000 in 2014/15, with 54 per cent of these in Greater London (56). London Councils has estimated that the policy will affect at least 11 per cent of London's workless households (59)<sup>9</sup>. It will be particularly significant for London compared to the rest of the UK because of the high rents in many areas of the capital (56).

From 2014, most people will be moved onto Universal Credit (UC), which is an attempt to combine benefits and simplify the existing system. When considered exclusively it is progressive – though there are winners and losers at all income levels – and it is predicted that more households will receive higher benefits under UC than will receive lower benefits, while the greater simplicity of UC will increase take-up of benefits (118;135). Transitional protection is expected to prevent losers at the point of transition, though the precise nature of transitional protection is unclear, as is what will qualify as a change of circumstances leading to a family's transitional protection being terminated (118;135). The DWP estimates UC will lift around 900,000 individuals out of poverty (135). The IFS supports the government's claim that UC will significantly reduce relative poverty across the UK, but it argues that this is more than offset by changes to the personal tax and benefit policy implemented by the current government prior to its introduction.<sup>10</sup> Taken together, and compared with a forecast assuming none of the reforms are implemented, the IFS predicts that the coalition government's tax and benefit reforms<sup>11</sup> will significantly increase child and adult poverty by 2015/16 and beyond (52). A substantial proportion of this increase is likely to be seen in London, particularly because of the disproportionately large number of households in London affected by the reforms.

### Differential impacts

Most analyses of the welfare changes – including the government's own impact assessments – conclude that the changes will lead to reduced incomes in many households. However, the impact of the changes will be greater for some than for others.

Most socioeconomic groups are impacted in some way by the reforms, for example the restrictions on previously universal Child Benefit will affect only those households where one parent has an income above £50,000. However, overall, the welfare changes up to 2013 will impact most heavily on the poorest. Households claiming means-tested benefits have, by definition, fewer financial resources. The IFS looked at the impact of the coalition's tax and benefit changes (except UC)<sup>12</sup> in London, and found that lower income households will be worse affected than higher income households (58). For example, the changes amount to 5.7 per cent of net income for the poorest fifth of Londoners, on average, compared with 1.7 per cent for the richest fifth (58). However, the IFS also found that UC is likely to be progressive: nationally, the bottom 60 per cent of the income distribution will gain on average, while the richest 40 per cent will lose out slightly in the long run (118).

It is not only workless households that will be affected by the changes. In-work poverty is high in London and those households in low-paid work of more than 16 hours per week will be worse off financially following the benefit changes, including UC (57). However, households working in part-time employment of less than 16 hours a week will gain financially (57).

Households with children in London are on average worse affected by the reforms than those without children (58;59). Looking at recent economic forecasts and tax and benefit policy announcements, the IFS predicts that median incomes of households with children will fall in real terms by 4.2 per cent between 2010/11 and 2015/16 across the country, compared with the projected fall for all households of 0.9 per cent (40). It should be noted that changes affecting households with children will be particularly problematic in London, given the high costs of childcare in the capital.

Larger families are disproportionately affected by the welfare reforms (56), particularly because the household benefit cap does not account for the number of people in the household. London Councils' analysis of the impact of the household benefit cap estimated that, following the introduction of the cap, 20 per cent of workless families in London with one child will face difficulties affording their rent, 25 per cent of families with two children, over 50 per cent of couples with three children and almost 80 per cent of couples with four or more children (59).

Lone parents have been identified as proportionally the biggest losers of the tax and benefit changes<sup>13</sup> (60). They are particularly vulnerable to welfare cuts because they tend to be on lower incomes (partly as a result of being a single-earner household) and face full-time childcare costs and/or require more flexible work and fewer hours. Because the large

majority of lone parents are women – more than 90 per cent (61) – the impact of benefit cuts is likely to be proportionately greater for women than for men.

IFS analysis of the impact of tax and benefit reforms found that the household incomes of single women are reduced by 8.5 per cent, more than other household types, yet this difference is driven by lone mothers – single women without children actually lose less than single men without children as a proportion of income (60;61). It is difficult to judge the real gender impact as the extent to which couples share money varies, but the benefits and tax credits being cut are more likely to be received by women in couples than by men (62). Research by the House of Commons Library looking at the personal tax and benefit changes announced in the June 2010 budget estimated that 72 per cent of the cash reduction in benefits comes from women and 28 per cent from men (63).

Minority ethnic households are likely to be more heavily impacted by the reforms because they are more likely to live on low incomes and receive income-related benefits, and to have larger families (64) – both factors which this chapter has shown increase a household's likelihood of reduced income following the reforms. However, this varies according to ethnic group. For example, while 50 per cent of Bangladeshi and Pakistani children live in families of three or more children, about 33 per cent of Black African children do (compared with only about 20 per cent of white British children) (136).

Disabled people aged 16–64 who receive Disability Living Allowance (DLA) are to be reassessed on the basis of new criteria, in a similar process to the Work Capability Assessment (WCA). Those considered eligible will be moved on to the Personal Independence Payment (PiP), which is unlikely to change substantially the value of the benefit they receive. The government anticipates that this reassessment process will reduce the caseload by about 500,000 people (137). Those who are not considered to be in need of additional care or support will in many cases face dramatically reduced incomes: they will lose their DLA/PiP and they will become subject to the household benefit cap. This will be particularly damaging for those who are reassessed wrongly, so it is essential that care is taken not to repeat the problems that occurred in the WCA process and to support vulnerable people, particularly those with mental health problems, through the process. Aside from increased vulnerabilities associated with their disability, disabled people are more likely to be financially vulnerable because they have lower than average savings and less access to affordable credit (as they are less likely to be in work or have a sustained work history) (138). Research by Demos found that disabled households were also likely to lose income from other government changes such as changes to pension income and the need to contribute to their care (138). Any changes will have a subsequent impact on carers.

## The Harrington Report

The Harrington Report reviewed the Work Capability Assessment (WCA) process for disabled people on Incapacity Benefit (IB) and found strong evidence that the system can be impersonal and mechanistic, lacking in transparency and often resulting in inaccurate decision-making – it has been reported that between 40 per cent and 70 per cent of those who appeal their WCA win their appeals, depending on whether or not they are represented (139;140). There are many risks associated with reassessment of disabled people, particularly people with mental health problems who may find it more difficult to engage or cope with the process, and there should be a role for involving the NHS in supporting people through reassessment and in the decision-making. Recipients of the Disability Living Allowance (DLA) are now to face a similar assessment.

## Key points

- Many elements of the changes to the welfare system will mean that many households are financially worse off and will need to live on a lower income.
- A household benefit cap will set a maximum amount a workless household can receive in total benefits: it is predicted that 54 per cent of an anticipated 67,000 UK households affected will be in Greater London in 2013/14.
- Universal Credit, taken alone, is progressive and likely to reduce poverty, though there are winners and losers at all income levels. However, when Universal Credit is considered alongside the rest of the tax and benefit reforms, poverty is expected to increase significantly more across the UK by 2015–16 and beyond compared to a situation in which the reforms had not been implemented.
- The changes are likely to impact low-income households, in particular:
  - Workless households and those in low-paid work of more than 16 hours per week
  - Households with children
  - Lone parents (90 per cent of whom are women); possibly also women in couples
  - Larger families
  - Some minority ethnic households
  - Disabled people who are reassessed and considered ineligible for the Personal Independence Payment.

## 5

# The housing and health impacts in London as a result of the economic downturn and welfare reforms

## Health impacts of housing

The type and condition of housing is closely related to the income of an individual, as those with a lower income, particularly those dependent on state benefits for their income, will have greater restrictions on the type of housing available to them. There are a number of different housing conditions that may constitute a risk to health, primarily felt by those on lower incomes. These include homelessness (including rough sleeping and living in hostels and temporary accommodation), overcrowding, insecurity of tenure, and housing in a poor physical condition (3). Further, high house prices and rents (partly influenced by the availability of housing and particularly relevant in London), energy prices and energy-inefficient properties reduce the amount of disposable income available to an individual, with resulting health implications.

## Fuel poverty<sup>14</sup>

Households in fuel poverty are likely to live in a cold home or make sacrifices in other areas such as the amount or quality of food they are able to purchase. Living in a cold home has direct health impacts including cardiovascular and respiratory diseases and mental health problems among all age groups (70;73). There were 24,500 Excess Winter Deaths<sup>15</sup> in England and Wales in 2009/10 and research has shown that these are almost three times higher in the coldest quarter than the warmest quarter of homes (73). Living in a cold home also has indirect impacts on health by negatively affecting dexterity and children's educational attainment, among other factors (73). Cold homes are more likely to be damp and mouldy. Mould can lower resistance to respiratory infections and trigger allergies such as asthma (73). Fuel poverty is more common among those further down the socioeconomic scale because of its relationship to income, and it contributes to health inequalities (3;73).

## Overcrowding

Living in overcrowded accommodation has significant social and health risks (3;59) and these can be long-term, with many studies concluding that overcrowding experienced in childhood negatively affects adult health (71). Evidence suggests that rates of respiratory disease, tuberculosis, meningitis and gastric conditions are significantly associated with overcrowding (70–72). There is evidence

that overcrowding can negatively impact children's education, future prospects, family relationships, and physical, mental and emotional wellbeing (72). Overcrowding is more common among particular minority ethnic groups, with the highest rates among Bangladeshi and Black African households (72).

## Homelessness

A paper published by the Department of Health defines homelessness as sleeping rough, or living in a squat, a hostel or sleeping on friends' floors (65). Several studies have shown that the average age at death of homeless people is low, at about 40–44 years (65). A study in Glasgow showed that homeless individuals had a risk of death 1.6 times greater than local non-homeless residents and 1.4 times greater than residents of the most socioeconomically deprived areas (66). For those with particular morbidities, being homeless meant a much higher risk of death, with drug users having a seven times higher risk of death (66). An article in *The Lancet* reported that rough sleepers are 35 times more likely than the general population to commit suicide and twice as likely to die from cancer (67). A national audit found that 82 per cent of homeless clients had at least one physical health need while 72 per cent had at least one mental health need, and almost one in three eats less than two meals a day (68). Homeless people have a high prevalence of alcohol and substance misuse and smoking (66;68). They are particularly vulnerable to tuberculosis, they are more likely than other Londoners to have highly infectious or drug-resistant strains of the disease and are less likely to continue treatment (67;69;141).

## Key points

- Housing conditions which constitute a risk to health, primarily for those on low incomes, include homelessness, overcrowding and housing in a poor physical condition.
- High housing and energy costs and energy energy-inefficient properties detract from the disposable income available to an individual, with resulting health implications.
- Living in a cold, damp home leads to a higher risk of poor health outcomes, including cardiovascular and respiratory diseases and mental health problems, among all age groups. Living in a cold home also has indirect health impacts, for example negatively affecting dexterity and children's educational attainment.
- Rates of respiratory disease, tuberculosis, meningitis and gastric conditions are higher in overcrowded households. Overcrowding can negatively impact children's education, future prospects, family relationships, and physical, mental and emotional wellbeing.
- Homeless people have a higher risk of physical and mental health problems. They are more likely to die from cancer or commit suicide, and their average age at death is just 40–44 years old. They also have higher rates of alcohol and substance misuse, smoking and tuberculosis.

## The housing effects of the economic downturn in London

The economic downturn will affect housing in two ways. First, adequate housing may be more difficult to afford during an economic crisis (77): the number of tenants evicted through the courts by private landlords increased by 17 per cent across the country between 2008 and 2011 (142). Households are more likely to be forced to live in poor housing conditions. Second, reduced government spending may mean that less is spent on developing social or affordable housing. However, this is not inevitable, and policies that support the development of accessible, affordable and appropriately sized housing may help to mitigate the housing impacts of the economic crisis.

### Housing supply

These problems are particularly relevant for London, where there is a huge demand for and shortage of housing (41). The cost of housing and rents in London continued to rise even during the economic difficulties and remain high, though average prices vary considerably across the capital (83;143). Reduced public spending on housing is concerning as evidence suggests that the only really significant surges in housing supply have come when government has paid for them (76;144). The Institute for Public Policy Research predicts that London will have a shortfall of 325,000 houses by 2025, based on the assumption that London builds only 20,000 houses per year (145). The Mayor's London Plan has set a target to provide an average of 32,210 net additional homes across London to 2015/16, 13,200 of which should be affordable, with priority given to affordable family housing which is much needed in London (74;75). This is consistent with the government's commitment to deliver up to 170,000 new affordable homes in the period 2011–15 (76), 55,000 of which are planned for London (75). Addressing London's shortage of affordable housing is crucial given the health impacts of poor housing conditions, overcrowding and homelessness, particularly in an economic climate where many households are facing lower incomes.

### Private rented sector

In London there is a greater proportion of people living in the private rented sector than in the country as a whole, particularly in more expensive Inner London boroughs (146). These people are more vulnerable to losing their home or living in poor conditions because of their lack of legal rights to a secure tenancy or to make improvements (147). Fuel poverty is also highest in this sector.

### Homelessness

The number of households accepted as homeless by local authorities in London fell every year between 2003 and 2009, but began increasing at the end of 2010 (148). In 2010, 9700 households were accepted as homeless and in 2011 this figure was 11,680 – an increase of 20.4 per cent (78). In London in 2010/11, one study found that 3,975 people slept rough at some point – an increase of 8 per cent on 2009/10

and of over a thousand people since 2005/06 (149). A disproportionate increase in young people sleeping rough has been reported in London, with a 32 per cent increase in under-25s reported between 2010/11 and 2011/12 even though the latter data set is for only eight rather than 12 months (79). A survey by Homeless Link found that by July 2008, two-thirds of homelessness organisations were reporting an increased demand for their services, while a majority were also facing reduced funding (150).

### Overcrowding

In addition to the difficulties in affording housing, nearly 11 per cent of London's population live in overcrowded housing, which is more than 800,000 people (143), and the number of children in London in overcrowded accommodation increased by 18 per cent between 2008 and 2011, to 24 per cent (80).

### Fuel poverty

The most recent GLA estimates suggest that 560,000 households live in fuel poverty, though this is likely to be an underestimate as the measure does not take into account the disproportionately high cost of housing in London (81). Although the number of people in fuel poverty is heavily dependent on fuel prices, which are rising faster than incomes, the economic and policy situation has a huge impact in determining the incomes and energy efficiency of low-income households who may be affected.

## Key points

- Adequate housing may be more difficult to afford during an economic crisis: nationally, the number of tenant evictions increased over the course of the recession. Households may be forced to live in poorer conditions.
- London has a shortage of homes and high housing costs. The government and the Mayor's London Plan have set targets for developing new affordable homes, though reduced public spending on housing means achieving these targets may be difficult.
- Comparing 2010 and 2011 data, the number of London households accepted as homeless by local authorities rose by 20.4 per cent. It was reported that the number of rough sleepers increased by 8 per cent in London, while the number of rough sleepers under 25 rose by at least 32 per cent.
- The number of children living in overcrowded housing increased by 18 per cent in London between 2008 and 2011.
- Recent estimates suggest at least 560,000 London households live in fuel poverty.

### The housing effects of the welfare reforms

From 2011/12, the maximum Local Housing Allowance (LHA) that a household can receive is set at the thirtieth percentile of local rents rather than the median as was previously the case. Further, caps to Housing Benefit will be introduced for each household size, withdrawing the five-bedroom rate altogether. From 2013, maximum LHA rates will be increased over time by CPI inflation rather than by reference to actual market rents, which is likely to increase the shortfall between LHA payments and the rents people have to pay over time (87). The other most significant reform is the overall household benefit cap, which will essentially cap Housing Benefit for most households as the likelihood of exceeding the cap is heavily dependent on housing costs (87). Overall, the changes will reduce the amount that households on benefits receive to cover their housing costs. There has been much concern that these changes will increase the likelihood of households going into rent arrears, being made homeless or being forced to move to a different neighbourhood.

House prices in London have remained resilient through the economic downturn and rents are higher in London than in the rest of the UK (143), which means that a greater number of properties available in London currently charge rents higher than benefit recipients can afford following the reforms. Setting the maximum LHA at 30 per cent rather than 50 per cent will affect the whole country, yet the Housing Benefit caps will disproportionately affect London, preventing those on benefits from living in the most expensive areas. Further, the household benefit cap is the same across the country and does not take London's higher housing costs into account (59).

Considering only the reforms implemented in 2011/12, it has been estimated that 106,000 London households will be affected, with approximately 27 per cent facing losses of £10 a week or less, while over 34 per cent will lose more than £20 per week (83). The DWP predicts that private rented tenants receiving Housing Benefit will lose an average of £22 a week in London following the 2012 changes (151).

Other estimates of the impact of any or all of the welfare reforms have predicted that, following the reforms, between 82,000 (83) and 133,000 (59) London households in receipt of Housing Benefit will be unable to afford their homes, with just 51 per cent of London neighbourhoods being affordable in 2012, compared to 75 per cent pre-reform, and further reductions to 36 per cent by 2016 mainly as a result of CPI uprating (as shown in Figure 5) (84)<sup>16</sup>. Only 20 per cent of Inner London neighbourhoods will be affordable by 2016, compared with 67 per cent pre-reform (84). In just two of the richest boroughs, Kensington and Chelsea and Westminster, it is estimated that 35,000 properties became unaffordable to Housing Benefit recipients following the January 2012 changes that reduced the benefit to 30 per cent of average rents and capped it for each household size, demonstrating the considerable variation between the number of affordable properties in different boroughs across London (85).

Figure 6 shows the maximum LHA allowed in each London Broad Rental Market Area (BRMA) before and after the LHA was capped and set at the thirtieth percentile of local rents rather than the fiftieth percentile. It can be seen that some areas and households are more affected than others: for example, a household in a five-bed property in central London could see their LHA fall from £2000 to £400 per week. In general, Central and Inner London, and larger property sizes, are the most heavily impacted (86).

Though it stands to reason that those boroughs with the most benefit recipients (more deprived) are likely to be worse affected by the welfare reforms as a whole, it is those (less deprived) boroughs with higher rents that will face greater reductions in the number of properties affordable under the new rules, with existing tenants facing larger shortfalls in their rent. Further, areas with more benefit recipients are also more likely to see rents fall in response to the reforms (see page 38 for a fuller discussion), which would mitigate the impacts to some extent. Therefore, it is difficult to ascertain the overall effects for a borough, though the number of benefit recipients and rental costs are likely to be key influences.

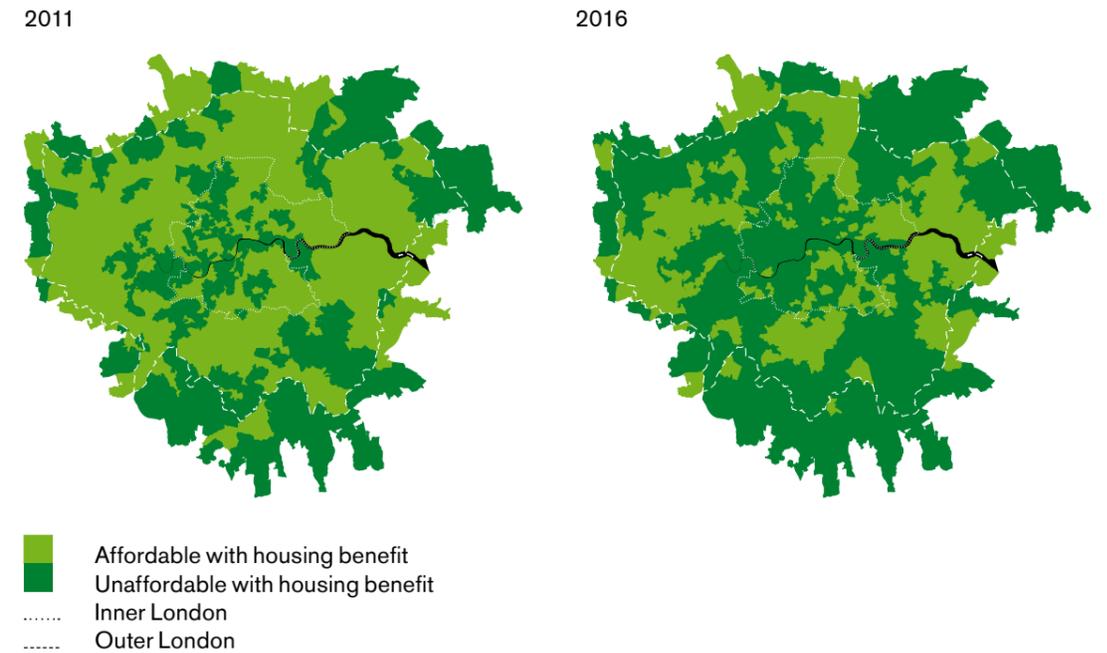
The DWP Impact Assessment of the Housing Benefit reforms finds that, “the cumulative impacts of these measures do not appear to disadvantage one group more disproportionately than another” (153). However, on closer inspection it again seems likely that some population groups will be affected to a greater extent than others.

Families with children, particularly larger families, tend to suffer most from the reforms. The DWP estimates that of those families affected by the household benefit cap, over 80 per cent have three or more children (56). Research by Shelter suggests that the reduction of the maximum LHA entitlement from the median to the thirtieth percentile of rents in the area means that larger families with four or more children would have their LHA cut in almost all areas (based on BRMAs) (87). Families with three children have their LHA cut in 30 per cent of areas, whereas two child families only lose out in 4–9 per cent of areas (87).

Particular policies are likely to cause disproportionate harm to certain groups of people in London. The uprating of non-dependent deductions is likely to affect households containing young people who are finding it difficult to leave home in London because of housing costs and problems finding a job. The introduction of the shared room rate for people aged 25–35 years may have particularly harmful implications for vulnerable single people such as those with mental health or substance misuse problems.

Many of these changes are only applicable to private tenants, therefore those living in the private rented sector will be most heavily impacted by the welfare reforms – though the potential impacts on housing demand and homelessness, for example, are of indirect interest to social landlords and local authorities (154). However, social renters will not be exempt from the changes: the uprating of non-dependent deductions and the reduction of Housing Benefit for working-age recipients living in under-occupied social housing may result in households

Figure 5 Neighbourhoods affordable to Housing Benefit recipients in 2011 and 2016



Source: Fenton A (2011) Housing benefit reform and the spatial segregation of low-income households in London (84)

Figure 6 Local Housing Allowance in London (rounded to nearest whole pound)

BRMA	After reform LHA 30th percentile Based on March 2011 LHA					Before reform LHA 50th percentile Based on March 2011 LHA					
	Shared	1-bed	2-bed	3-bed	4-bed	Shared	1-bed	2-bed	3-bed	4-bed	5-bed
Central	138	250	290	340	400	141	375	550	795	1250	2000
Inner East	91	225	280	330	400	101	250	310	365	465	573
Inner North	99	250	290	340	400	115	275	350	485	610	750
Inner South East	85	177	225	277	358	90	196	254	300	415	550
Inner South West	100	219	288	340	400	110	253	317	390	535	785
Inner West	99	219	282	340	400	114	242	320	418	554	950
North West	80	173	208	277	323	88	179	219	288	358	462
Outer East	72	162	196	242	290	81	168	208	265	300	375
Outer North East	68	150	185	219	300	74	156	196	242	323	427
Outer North	79	173	225	277	346	92	179	235	300	380	550
Outer South East	73	150	180	213	277	81	156	190	231	300	381
Outer South	76	150	185	231	300	84	157	196	254	323	392
Outer South West	80	183	231	277	358	86	196	254	300	404	531
Outer West	75	162	198	242	288	86	173	208	254	309	346

Source: Department for Work and Pensions (86), accessed through the Guardian datablog (152) and adjusted by the author

going into rent arrears, moving to another property or non-dependents being required to move out of their current home (154).

Because London is disproportionately affected, the Mayor of London has secured a package of transitional arrangements for Londoners, including more time for existing claimants and boroughs to prepare for the changes, a considerable proportion of the Discretionary Housing Payment funding and direct payments to private landlords who reduce their rents to affordable levels (75).

### What will affected households do?

#### Take up employment or re-negotiate the rent

The government hopes the welfare changes will incentivise people to take up paid employment, though as discussed previously, the current lack of jobs and amount of in-work poverty may mean that people are unable to find a job and may not be much better off if they do.

It has been suggested that existing LHA rates drive up rents artificially and private landlords may reduce their rents in some areas in response to the Housing Benefit caps (59;83). Analyses of previous UK Housing Benefit reforms suggest that landlords may bear some if not all of the burden of Housing Benefit reductions, though it is difficult to be conclusive (155). If this were the case, the extent to which household incomes would be affected by the reforms would be less than otherwise expected. However, there is greater demand for private rented housing in London than elsewhere in England which means London landlords have weaker incentives to reduce rents compared with other parts of the country, as there is more likely to be someone else willing to rent (84). In a survey of landlords who currently rent properties to Housing Benefit recipients in London, 60 per cent responded that they would not reduce rents by even a small amount if the tenants could no longer pay full rent due to Housing Benefit changes and this rose to over 90 per cent if the shortfall was £20 a week or more, though this does not take into account the fact that they may be forced to reduce rents because of changes in demand (83). Households unable to renegotiate their rent will need to find an alternative solution.

#### Make up the shortfall or go into rent arrears

Households may be able to make up the rent shortfall from their low wage or other benefits (59), leaving them with less disposable income with which to lead a healthy life. Others will be unable to make up the shortfall and go into debt or rent arrears, leading eventually to repossession or non-renewal of the tenancy (59). This may, over time, reduce the number of private landlords willing to rent to tenants receiving Housing Benefit, reducing the affordable housing supply further (156).

#### Become homeless

A rise in claimants unable to afford their current rent may increase the number of homeless people in the capital. Aside from the severe social and health

implications of homelessness for the individuals concerned, there will be increased pressure on local authorities to re-house them in more affordable or temporary accommodation. London Councils has predicted an increase in people housed in emergency or nightly accommodation and there have been reports of boroughs block-booking accommodation outside of London (59).

#### Compromise on housing conditions

Households remaining in less affordable areas might compromise on housing conditions. There is a risk of increased overcrowding (59), particularly due to the removal of the five bedroom rate and the reduction of LHA rates to the thirtieth percentile (153). The new penalty for under-occupiers in social housing may, however, release more homes for social rent and reduce costs and overcrowding in the long term, though under-occupation is less common in London than elsewhere in the country (59).

There is a further risk that more people will move into damp, energy-inefficient properties. Reduced incomes following the impact of all of the benefit changes will mean that many families will need to spend a larger proportion of their income on covering household bills, leading to an increase in the numbers of households in fuel poverty. London Councils used modelling to predict that when housing and childcare costs had been taken into account, most workless and working families earning the minimum wage in London would be fuel poor following the introduction of UC (170). Similarly, other changes to government policy such as the decision to end Warm Front in 2013 (which will stop central government funding to support low-income and vulnerable households in fuel-inefficient homes), alongside increasing energy prices, will increase the number of households living in cold homes as they do not have enough money to pay their heating bills (157) or move to a fuel-efficient home.

#### Move to another area

Other households are likely to move to a less expensive area of London or out of London altogether (59;153). Aside from the logistical difficulties people might face when moving house – and these will be more pronounced for benefit recipient households with fewer resources and less time to make arrangements – these people are forced to move from areas in which they are likely to have built up networks, have family and friends, and a role in the community. They may be more likely to experience social isolation which is detrimental to health (3;158). Those in employment may face an extended commute with its negative time and cost implications and in some cases a change of location may result in removing them from the labour market altogether.

A number of recent reports predict significant migration of low-income private tenants between London boroughs as a result of the reforms, primarily from less to more affordable areas (59;84). Further, those areas that will remain affordable in London after the reforms set in are those that already tend to have high rates of deprivation, with less

attractive infrastructure and opportunities in terms of transport and employment (84). These areas are likely to see an influx of LHA claimants following the reforms, exacerbating further the concentrations of poverty, deprivation and unemployment in those areas (84). These places will see a rise in the number of people claiming benefits and on housing waiting lists, as well as increased demand for additional services such as schools and healthcare (153). Less affordable areas of London will also see a change in service demand reflecting the migration of more deprived households out of the area. This movement will create a residualisation effect, intensifying the segregation of poor and better-off households in London, with negative implications for community cohesion that is supported by mixing between different communities (59;84). Living in a deprived area increases an individual's risk of poorer health, and research suggests that these effects may be worse for poorer people as they are more dependent on the neighbourhood's collective resources (159).

As families with children are heavily affected by the changes, it is not unlikely that there will be significant movement of children across London, with potential implications for support to children in need and at risk, the provision of school places, the disruption of education and further socioeconomic polarisation between school catchment areas (59).

The fact that there are a number of options open to benefit recipients means that it is difficult to know exactly what impact the changes will have, as it is not possible to predict their behavior (56;59;146). As described above, multiple additional social problems associated with poverty, debt and community cohesion are likely to arise beyond the individual households directly affected. The risks to physical and mental health of overcrowding, homelessness, debt and poverty – all possible outcomes of the changes to LHA – are well documented (3) and are likely to increase health inequalities, particularly as it is the poorest who will be the ones affected by the benefit changes in the first place.

### Key points

- Overall, the reforms will reduce the amount that households on benefits receive to cover rents, and London will be disproportionately affected because of its high housing costs.
- Estimates suggest that between 82,000 and 133,000 households will be unable to afford their homes following the reforms, with only 36 per cent of London's housing affordable to those on LHA by 2016, compared to 75 per cent pre-reform.
- There is considerable variation between different areas of London:
  - Areas with more benefit recipients have more households at risk of being affected by the reforms, yet they are also more likely to see rents fall, meaning the real impact on their incomes is less.
  - Areas with fewer benefit recipients are likely to be richer areas with higher housing costs; therefore, existing tenants will face greater rent shortfalls.
- The most heavily affected will be families with children, particularly larger families, plus private tenants, as the majority of the changes only apply to them. Particular policies will cause disproportionate harm to certain groups – for example the uprating of non-dependent deductions on young adults.
- Rents might fall in response to the Housing Benefit reforms, particularly in areas with more benefit recipients – though landlords appear resistant to reducing their rents in the short-term. Households facing a reduction in benefits significant enough to make their current property unaffordable will need to find an alternative solution, most likely one of the following options:
  - Take up paid employment (if available and pays enough)
  - Re-negotiate the rent with their landlord
  - Go into rent arrears leading to repossession or non-renewal of the tenancy
  - Become homeless
  - Become overcrowded
  - Compromise on housing conditions
  - Move to a less expensive area or out of London altogether.
- As a result of the welfare reforms, London might expect to see significant migration within and between different boroughs as more areas become unaffordable, and/or an increase in homelessness, repossessions and overcrowding. Boroughs with higher levels of inward migration will receive increased demand from their own population, while areas with outward migration will face reduced demand.
- This may have wider impacts on services provision, community cohesion and physical and mental health; and worsening of a range of social and health conditions; and widening inequalities.



## 6 How London's demographics might influence or be influenced by the economic downturn and the welfare reforms

### A demographic profile of London

#### Population change

London's population has increased steadily in recent years and is predicted to grow from 7.8 million in 2011 to 8.06 million in 2016 to 8.32 million by 2021 (74). There is considerable international and internal migration to, from and within London, though this flow is not significant enough in one direction to contribute substantially to the overall population growth (though it is likely to impact differently on the populations of individual boroughs) (160).

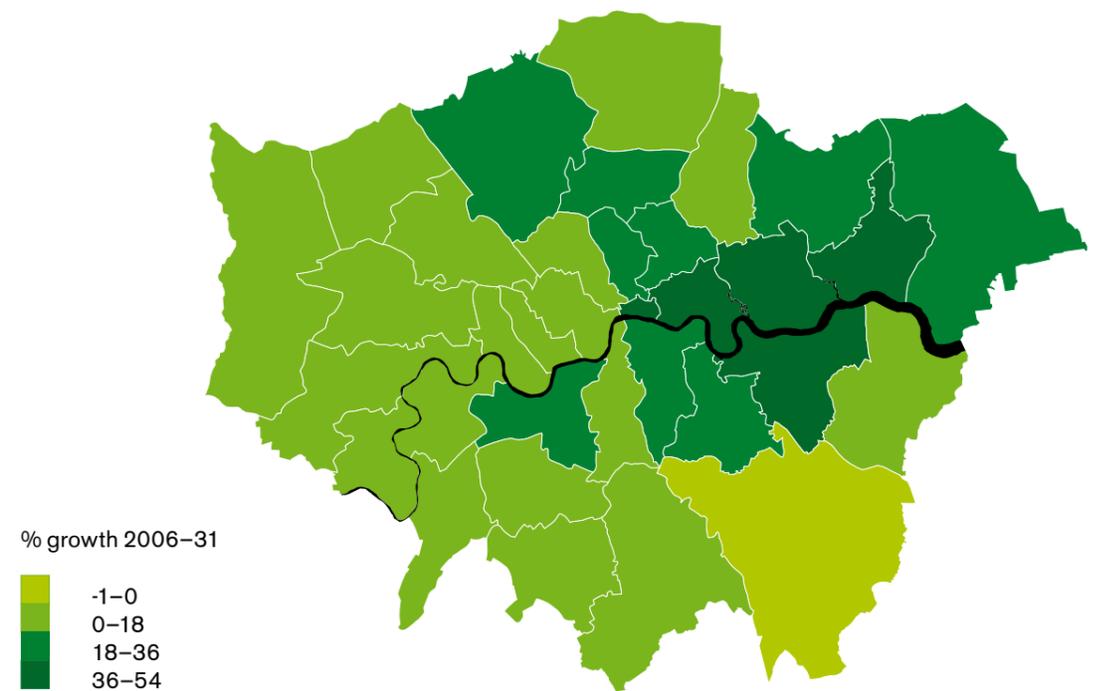
Rather, the consistent population growth is driven by natural increase. Although mortality rates have fallen, births have risen considerably – the total fertility rate increased in every London region except Inner West between 2001–08 and there is considerable variation in fertility rate by borough (160). Fertility rates are highest in areas with a large minority ethnic population: “the increase in births in

London since 2001 has been entirely due to mothers born outside the UK; births to mothers born in the UK has fallen since 2001” ((161) cited in (160)). Similarly, though, mortality rates vary significantly between boroughs, with lower life expectancies linked to greater deprivation (3;160).

#### Age

In mid-2010, 19.6 per cent of London's population were under 16, compared with 18.7 per cent in England, and 43 per cent were aged 20 to 44 compared with only 34.4 per cent of the England population (163). Only 11.5 per cent of the population were 65 or over compared with 16.5 per cent for England (163). It is predicted that London's population will continue to be younger than anywhere else in England and Wales (74). However, the older old in London are also predicted to increase – the over 80s by 40 per cent by 2031, with a particularly strong increase in the over-90s ((164) cited in (165)).

Figure 7 Estimated distribution of population growth 2006-2031



Source: GLA 2009 Round Population projections, GLA Intelligence Unit (74;162) – see appendix 3 for a table of the data

### Ethnicity

London is ethnically diverse and it is predicted to continue to diversify, with an increase in minority ethnic populations (31;74;160). This is far more significant for some boroughs than others, with particular minority ethnic populations more likely to live in particular areas of London. Around a half to a third are from a minority ethnic group in Inner and Outer London respectively as opposed to only 15 per cent in the rest of England (166). About 40 per cent of people from minority ethnic communities live in low income households, whereas for white people this figure is more like 20 per cent, though this differs between minority ethnic group (136).

### Household type

Projections for London in 2008–33 show that the largest increase is likely to be in one-person households (a 54 per cent increase and 75 per cent of the total household increase), while lone parents are the fastest growing household type (a 62 per cent increase) (167). Very little change is predicted over this period in couples and other households (167).

### How London's demographics might influence groups affected by the economic downturn and welfare reforms

London has a relatively young, mobile and ethnically diverse population, as shown in the demographic profile above. Given the demographics, it is likely that certain social and health impacts of the economic crisis and welfare reforms will be more significant in London than elsewhere in England. Particular 'at risk' groups identified in this report are more commonly found in London than elsewhere:

- London has and will continue to have a young population (74). Young adults have been disproportionately affected by the unemployment resulting from the economic crisis and households with children face a greater reduction in benefits following the welfare reforms.
- London is ethnically diverse and projected to diversify further, with an increase in minority ethnic populations (31;74;160). Furthermore, the population increase is driven largely by migrants. Minority ethnic and immigrant populations generally have lower incomes which means they will be more heavily affected by the welfare reforms, and particular ethnic minorities are far more likely to live in overcrowded accommodation which raises the likelihood of an increase in overcrowding in the capital following the welfare reforms.
- There are already proportionally more lone parent households compared with the rest of the UK, and they are predicted to be the fastest growing household type in London between 2008 and 2033 (167). Lone parent households are predicted to suffer the greatest losses following the tax and benefit changes (60).

### How London's demographics might be influenced by the economic downturn and the welfare reforms

Further, the economic crisis and the welfare changes are likely to have an impact on London's demographics. Crucially, the impacts on housing of the welfare reforms – and in particular the caps on housing and household benefit – are predicted to cause considerable migration between London boroughs and out of London altogether. This will impact the demographics of London's boroughs in different ways, with poorer households moving to more deprived areas and out of London. Poorer areas and particularly Outer London may experience a disproportionate rise in their population with households moving in, increasing demand among their own population. At the same time, more expensive areas are likely to experience outward migration and a reduced demand from their population – though the high demand for rented accommodation in London means that richer households are likely to move in to fill the space left by households on benefits no longer able to afford their property.

As Figure 7 shows, some of the more deprived London boroughs, particularly in the North East, are already predicted to see a greater population increase over the next 20 years, so this will be compounded by the population impacts of the welfare reforms.

Population growth will put pressure on housing and other resources, at a time when these services are under additional pressures from the macroeconomic conditions, reduced budgets and internal migration. It is crucial that this is factored into planning decisions and that housing and other social services in London are sufficiently resourced to deal with these additional pressures.

### Key points

- Particular groups identified in this report as being more 'at risk' following the economic and welfare changes are more commonly found in London than elsewhere and may be increasing, including young people, minority ethnic and immigrant populations, and lone parent households.
- The welfare reforms are predicted to cause migration between London boroughs and out of London altogether. Poorer areas and Outer London may experience a disproportionate rise in their population because of the inward migration of benefit-recipient households, while more expensive areas might experience a reduced population as these households move elsewhere.
- At the same time, London's population is predicted to increase from 7.8 million in 2011 to 8.06 million by 2016, and this increase is higher in poorer areas.
- Population growth will put additional pressures on housing and other resources, at a time when these services are already under additional pressures due to the macroeconomic conditions, reduced budgets and internal migration. It is crucial that housing and other social services in London are sufficiently resourced to deal with these additional pressures.



## 7 Development of a framework of indicators

A framework of indicators that will help to track changes in key determinants of health and the impact of the economic crisis on health and wellbeing is in development for use at the local authority and pan-London levels. This will allow boroughs to assess likely impacts on health and health inequalities.

The framework will include a small number of indicators across four domains: employment, income, housing and health/wellbeing. The four domains and potential indicators have been generated through this evidence review, discussions within the Institute of Health Equity team and with key stakeholders, including the London Health Inequalities Network (former Spearhead PCTs), Greater London Authority, London Health Observatory, London Councils and representatives of the community and voluntary sector (CVS) and of private sector organisations.

An expert workshop, attended by representatives of pan-London and local intelligence teams, and consultation with SEDUG (the London Social Exclusion Data Users Group) have also been held and further work to test and refine the framework of indicators is ongoing at the time of publication of this report.

The indicators framework will include around 12 core indicators which will be manageable for quarterly monitoring at the local authority level and which, most importantly, will provide useful information that is sensitive to change on the short-term basis required to track impact and inform policy and decision-making and commissioning. Criteria for inclusion of indicators in the framework require that they be:

- Sensitive to short-term (within year) and medium-term (within one to three years) change, as well as longer-term change
- Sensitive to actual impacts and also to potential, emerging impacts so highlighting possible ‘directions of travel’
- Available from routinely collected data – but not necessarily from conventional sources; for example we are looking at a range of useful community and voluntary sector data
- Timely and up to date – providing information that gives a real-time view of what is happening
- Providing information of impact at a range of levels from neighbourhood to pan-London levels
- Providing information about the impact on existing or emerging vulnerable groups
- Providing information about the impact on inequalities

- Inclusive of the potential for modeling/enabling analysis of forward projections/trends.

The framework of indicators will be subject to extensive consultation and testing with data experts and local authorities in London during 2012 before being finalised and published along with ‘guidance for use’ and promoted across all local authorities in London early in 2013.



## 8 Recommendations on how to mitigate the negative impacts

The previous sections provided evidence about the likely impacts on health of the economic crisis and welfare reforms. This was done by assessing likely impacts on three key social determinants of health: housing, income and employment. Health inequalities are likely to widen and both short- and long-term health impacts may be worse for many Londoners, particularly for those who are already disadvantaged.

Reducing these worse health impacts or even changing the likely trajectories is particularly difficult in an era of reduced spending for local authorities and national government. However, there are several reasons why it is important to take action:

- Good health is highly regarded by the whole population and action to protect and enhance health for all is one of the most important priorities for governments – nationally and locally.
- Local authorities have responsibility for or influence over many of the areas that directly affect health, including housing, employment and income.
- The determinants of health and determinants of social cohesion are closely related.
- **There are economic costs of doing nothing.** Not taking action to reduce health inequalities is expensive. *Fair Society, Healthy Lives* calculated that nationally, inequality in illness accounts for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20–32 billion per year and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year (3). Much of these costs will fall to local authorities. Worsening health inequalities will mean even higher costs of doing nothing.
- **There are human costs of doing nothing.** *Fair Society, Healthy Lives* estimated that if everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life. They would, in addition, have had a further 2.8 million years free of limiting illness or disability (3).

The recommendations proposed are made within this context.

### 1 ASSESS AND RESPOND TO AREA NEEDS

Local authorities should calculate the costs of doing nothing to tackle health inequalities both in terms of economic impact and in relation to years of life lost.

#### Local measurement and monitoring

Measurement will not mitigate the impacts of the economic downturn or welfare reforms but it will help to monitor the situation and enable the most effective distribution of resources to reduce health inequalities. Measurement will also give an indication of the likely health and health inequalities impacts of changes in housing, employment and income.

This report forms the basis upon which a set of indicators can be built. These will be based on data which is readily available related to the evidence of impacts on health from income, housing and employment.

#### Cross-sector working

Households may face multiple problems. For instance they might require debt relief services, housing advice and mental health services. Joined-up working and quick referrals to other services would help to get professional support to those who need it. Within London, Directors of Adult Services, with Directors of Public Health have a role to coordinate services and ensure health equity is at the heart of local authority plans and strategies. Health and Well-Being Boards and Joint Strategic Needs Assessments should facilitate this kind of cross-sector working.

### 2 ENSURE SUFFICIENT INCOMES

#### Strengthen financial incentives to work

Where work is available, residents should be better off in work than out. However, for some households this may not be the case, particularly families with children. The following could help:

#### Sufficient income

Any income from work needs to be sufficient to fund a healthy life, and the income should feel secure enough to maintain that life. For the income to be an incentive to work, and more attractive than benefits, it will need to cover the costs of going to work – for example childcare, alongside decent housing, school meals, travel and clothing for work and the cost of prescriptions.

Local authorities should ensure that everyone within their organisation, contractors and any other organisations over which they have influence receive a minimum income for healthy living. The London Living Wage should be set at a level that supports this and employers of workers in London should be encouraged to pay staff at this level.

#### Good quality and affordable childcare

Good quality, widely available Early Years Services and accessible, affordable childcare are needed to support families with children, who are one of the groups likely to be worst affected by the welfare reforms. Good quality Early Years Services are also a key determinant of health and other life chances. A good quality affordable childcare system should contribute to incentivising employment, reducing child poverty and strengthen gender equality, all of which have been shown to narrow health inequalities.

### 3 ENSURE SUFFICIENT AND AFFORDABLE HOUSING

**Accessible, affordable, and appropriately sized housing** through considering policies such as:

- Supporting the development of more affordable homes
- Developing more social rented housing
- Implementing rent controls
- Bringing empty homes back into use
- New schemes such as Affordable Rent<sup>17</sup> and the New Homes Bonus<sup>18</sup>.

**Reduce fuel poverty.** Action to reduce fuel poverty in London should include (a) improving the energy-efficiency of homes through interventions based on evidence of what works, prioritising households in the private rented sector; (b) tighter controls and demands on fuel companies to keep prices affordable; and (c) measures to ensure household incomes are sufficient to enable householders to keep their homes warm (168). Further, action should be taken to prevent landlords using expensive energy metres.

### 4 ENSURE AN ADEQUATE SUPPLY OF GOOD JOBS

#### Stimulate employment

Employment, in good jobs, is good for health. London boroughs should seek to stimulate the demand for labour, and particularly for young people, men, and those with lower-level skills and education.

#### Encourage 'good' work

Local employers should be encouraged to provide 'good' work: "Jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from

adverse working conditions that can damage health" (3). This might include supporting employers to invest in health and wellbeing, and in good quality part-time work opportunities, and building resilience training into apprenticeship programmes.

### 5 SUFFICIENT PROVISION OF SERVICES TO COPE WITH LIKELY ISSUES

Local authorities should ensure that there are adequate services to support those negatively impacted by the recession or welfare reforms. These services should be implemented in a way that reflect proportionate universalism – universal policies implemented with a scale and intensity that is proportionate to the level of disadvantage. Consideration should also be given to changes in demand caused by migration between London boroughs. Specifically, local authorities should ensure they have adequate:

- **Advice and information services**, including financial and debt relief services, housing advice and benefits advice – which are cost-effective ways to increase incomes in low-income households (41). It may be desirable to provide additional legal aid to households facing particular problems. Significant cuts to advice and other adult services are being made in London at a time when they are needed most (169). Many households are not aware of the benefit changes and local authorities should do all they can to ensure that affected households are fully informed about the changes, how they will be affected, help them to understand their best options and where to get advice if they face difficulties.
- **Mental health services** to support the predicted rise in mental health problems during an economic downturn. Some services require a pan-London response as there may be insufficient demand in individual boroughs; these include talking therapies in other languages and specialists in particular conditions.
- **School places and GP services**, which may face reduced or increased demand if there is significant migration between boroughs following the welfare reforms.
- **Inter-borough safeguarding** of vulnerable people who may slip through the gaps of service provision, such as children in need of protection or adults with a learning disability.
- **Coordinated provision of services for rough sleepers and the homeless.**

## NATIONAL MEASURES

At a national level, there are measures that the government might take to reduce negative impacts on health inequalities.

- 1 **Health equity impact assessments of all policies**
- 2 **Review the welfare reforms** with regard to their impact on London and across the socio-economic gradient.
- 3 **Take a proportionate universalist approach to spending cuts.** Those services facing reduced spending or being decommissioned should not be those which will disproportionately impact those lower on the socioeconomic scale. These services include welfare spending, social housing, Children's Centres and the NHS. The government should change the distributional pattern of the spending cuts by doing more of the fiscal consolidation through tax rises and less through cuts to benefits and departmental spending. Allocation formulas should be reviewed.
- 4 **Active Labour Market Programmes** to achieve timely interventions to reduce long-term unemployment, and unemployment among under-25s.

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## List of abbreviations

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ALMP	Active Labour Market Programme
BRMA	Broad Rental Market Areas
CPI	Consumer Price Index
CTB	Council Tax Benefit
CTC	Child Tax Credit
DFLE	Disability-Free Life Expectancy
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
EHRC	Equality and Human Rights Commission
ESA	Employment and Support Allowance
ESRC	Economic and Social Research Council
GDP	Gross National Product
GLA	Greater London Authority
HB	Housing Benefit
IFS	Institute for Fiscal Studies
IMD	Index of Multiple Deprivation
IB	Incapacity Benefit
IS	Income Support
JSA	Job seeker's Allowance
JRF	Joseph Rowntree Foundation
LHA	Local Housing Allowance
LLW	London Living Wage
MIHL	Minimum Income for Healthy Living
NEET	Not in employment, education or training
PiP	Personal Independence Payment
RPI	Retail Price Index
UC	Universal Credit
WCA	Work Capability Assessment
WHO	World Health Organization
WTC	Working Tax Credit

# Appendices

## 1. An outline of the welfare reforms

Since taking office in 2010, the coalition government has introduced a number of reforms to the welfare system, primarily through the 2010 Comprehensive Spending Review and the 2011 Welfare Reform Bill. The main reforms which might affect employment, income, housing and health inequalities of Londoners are outlined in the table below.

Implementation	The Reform	Impact
<b>MAIN WELFARE REFORMS</b>		
April 2011	Start to use CPI rather than RPI to uprate all benefits	Benefits are likely to have a lower value than they might otherwise have done and the shortfall will accrue over time
October 2011 (delayed until January 2012)	Maximum LHA set at the 30th percentile of local rents, rather than the median. This effectively means claimants will only be able to choose from 30 per cent of properties in their local area of the appropriate size for their family rather than 50 per cent	Lower HB for households paying more than 30 per cent of the average rent for that size property in their area
April 2011 (delayed until January 2012)	Capping maximum LHA payable for each property size: £250/week for 1 bed; £290/week for 2 bed; £340/week for 3 bed; £400/week for 4 or more bed (ends 5 bedroom rate)	Lower LHA for households eligible for the 5-bedroom rate; lower LHA for claimants whose current rent exceeds the cap
April 2013	Increase maximum LHA rates over time by CPI inflation, rather than by reference to actual market rents	Over time this is likely to increase the shortfall between LHA and rent costs
April 2013	Cap the amount a workless family can receive in benefits to no more than an average family gets from work after tax, at around £500/week for couple and lone parent households and around £350/week for single adult households. Does not apply to working households	Lower benefits for households who might otherwise exceed the cap. Expensive housing costs are the most likely reason for exceeding the cap and households may need to re-think their housing options
<b>TAX CREDIT CHANGES</b>		
April 2011	Remove the baby element of the Child Tax Credit	Reduced income for families with children under one year
April 2011	Reduce the percentage of childcare costs that parents can claim through the childcare element of the WTC from 80 to 70 per cent	Reduced income for families with children
April 2011	Withdraw the family element of the WTC for those earning over £40,000, instead of £50,000	Reduced tax credit eligibility for higher income families with children
April 2011	Freeze the basic and 30 hour elements of the WTC for 3 years	Reduced income for some receiving WTC for 3 years
April 2011	Increase in the rate at which tax credits are withdrawn from 39 to 41 per cent	Reduced income for some receiving WTC
April 2011	Increases in income of more than £10k (rather than £25k) will reduce tax credit payments within that same year	Short-term reduced income for some receiving WTC, whose circumstances alter

April 2011	Child element of the tax credit increased by £180 above CPI indexation	One-off payment for households with children
April 2012	Couples with children must work 24 hours a week between them, with one partner working at least 16 hours a week in order to qualify for WTC (exceptions apply <sup>19</sup> )	Couples with children working 16–24 hours a week will lose their entitlement to WTC
April 2012	Falls in income of up to £2500 will not increase tax credit payments until the following tax year <sup>20</sup>	Short-term reduced income for some receiving WTC whose circumstances alter
April 2012	Reduced income limits for CTC. Actual rates are not yet definite, income limit depends on individual circumstances	Reduced tax credit eligibility for higher income families with children
April 2012	Payments can only be back-dated one month prior to claim, instead of three	Potential short-term (2 months maximum) reduced income for some receiving WTC whose circumstances alter
April 2012	50-plus element of WTC will end. This causes changes to number of working hours needed to receive WTC	Reduced incomes (and in some cases reduced eligibility for WTC) for those over 50 receiving WTC
April 2013	Increases in income of more than £5k (rather than £10k) will reduce tax credit payments within that same year ('introduction of a disregard for income falls')	Short-term reduced income for some receiving WTC, whose circumstances alter

#### HOUSING BENEFIT

January 2012	Increase the age threshold for the Shared Room Rate in Housing Benefit from 25 to 35	Reduced LHA for single people aged 25–34
April 2011	Deductions for non-dependents living with HB claimants increased	Lower HB for claimants living with non-dependents
April 2011	HB claimants with disability and non-resident carer entitled to funding for extra bedroom	Disabled HB claimants with a non-resident carer will receive funding for an extra bedroom
April 2011	Stop claimants' entitlement to keep up to £15 'excess' above actual rent if it was below the maximum LHA allowable	Lower HB for those claiming less than maximum LHA allowable
April 2013	Reductions in HB for those of working age living in social housing that is under-occupied	Reduced HB for working-age claimants living in under-occupied social housing

#### OTHER WELFARE CHANGES

April 2011	Freeze in Child Benefit rates for three years	Reduced income for families with children
April 2011	Lone parents with a child over 5 moved from Income Support to JSA	Lone parents will be required to actively seek work
April 2011	Sure Start Maternity Grant limited to the first child	Loss of a household's Sure Start Maternity Grant for all but the first child
January 2011	Health in Pregnancy Grant (£190 to all expectant mothers) abolished	Loss of one-off payment to pregnant mothers
January 2013	Withdraw Child Benefit from families where one parent earns more than £50,000	Reduce incomes for families with children where one parent earns more than £50,000
April 2012	Time limit contribution-based ESA for those in the Work Related Activity Group	Possible reductions for some in the Work Related Activity Group
April 2013	Introduce objective medical assessments for all DLA claimants	Little change in income if assessment confirms eligibility for PIP. Reduced income if assessment does not consider the individual to be eligible
April 2013	Reduce spending on Council Tax Benefits by 10 per cent and localise it	Reductions in CTB for individual households or the local authority to bear

#### Universal Credit

Universal Credit will replace all existing benefits and tax credits in an attempt to simplify the benefits system. Universal Credit will be introduced in October 2013 for new claimants, with existing claimants moving over between April 2014 and October 2017, thus a significant number are likely to remain on the existing system during the period with which this report is concerned (58). The complexity of the existing benefit and tax credit system is likely to have contributed to the low take-up of benefits, particularly among some groups, therefore the Universal Credit may increase benefit take-up.

#### Conditionality measures in the 2011 Welfare Reform Bill, to be implemented from January 2012 (116)

- Lone parent conditionality: Lone parents with a child aged 5 or over moved from Income Support (IS) to Job Seeker's Allowance (JSA)/ Employment and Support Allowance (ESA) – previously this was the case for lone parents with a child aged 7 or over.
- Claimant commitment: A claimant commitment introduced for those on JSA, ESA and IS, which clearly sets out a claimant's responsibilities in return for benefit payments. Claimants must accept these before they are paid.
- Sanction reform: JSA, ESA and IS sanctions have been reformed in an effort to encourage compliance more effectively. There is no consistent set of sanctions.
- Hardship payments: Hardship payments made to a JSA or UC claimant will now be recoverable and time-limited.

#### 2. Slope index of inequality (SII) in male and female life expectancy (LE) at birth by London borough, 2008–10

Name	LE SII Male	LE SII Female
England	8.9	5.9
London	7.5	4.8
Barking and Dagenham	5.2	2.4
Barnet	7.6	4.7
Bexley	7.8	3.4
Brent	8.8	1.2
Bromley	7.8	6.2
Camden	11.6	6.2
Croydon	9.5	5.8
Ealing	6.2	3.9
Enfield	8.2	6.3
Greenwich	9.1	7.0
Hackney	3.1	4.5
Hammersmith and Fulham	7.9	5.4
Haringey	8.3	4.3
Harrow	8.1	4.2
Havering	6.9	4.2
Hillingdon	7.0	5.7
Hounslow	6.8	4.2
Islington	6.5	5.6
Kensington and Chelsea	6.9	2.5
Kingston upon Thames	5.8	4.3
Lambeth	5.3	3.8
Lewisham	6.8	4.6
Merton	5.9	5.3
Newham	5.0	5.5
Redbridge	7.3	2.4
Richmond upon Thames	5.9	4.1
Southwark	10.4	8.6
Sutton	9.0	5.5
Tower Hamlets	12.3	4.9
Waltham Forest	7.1	5.5
Wandsworth	8.9	6.8
Westminster	16.9	9.7

Source: London Health Observatory (1)

### 3. GLA population projections 2006–2031

London local authority	Population estimate 2006	Population estimate 2031
Camden	203,439	237,553
Kensington and Chelsea	166,391	180,429
Westminster	210,398	228,792
City of London	8,850	12,638
Hackney	217,651	261,886
Hammersmith and Fulham	175,795	195,699
Haringey	230,315	260,682
Islington	188,882	244,384
Lambeth	285,987	343,556
Lewisham	263,516	314,861
Newham	259,274	326,599
Southwark	267,124	343,878
Tower Hamlets	221,037	313,836
Wandsworth	282,741	328,904
Barking and Dagenham	169,074	219,827
Barnet	323,889	387,956
Bexley	217,942	226,752
Brent	274,119	298,119
Bromley	299,414	315,712
Croydon	334,513	375,272
Ealing	310,317	347,470
Enfield	287,873	310,482
Greenwich	230,505	289,253
Harrow	216,003	230,949
Havering	228,209	262,243
Hillingdon	248,371	283,796
Hounslow	222,488	253,995
Kingston upon Thames	152,131	168,655
Merton	194,784	209,395
Redbridge	248,161	276,834
Richmond upon Thames	181,919	193,405
Sutton	182,745	192,967
Waltham Forest	223,021	247,689

Source: GLA 2009 Round Population Projections, GLA Intelligence Unit (162)

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## Endnotes

### Denoted by \* in the text

- 1 For example, while both Spain and Sweden faced severe economic problems in the 1980s–90s, Spain saw a relative increase in suicides and Sweden, with its strong welfare state and Active Labour Market Programmes, saw its long-term decline in suicides continue (25). During the East Asia financial crisis of the 1990s, both Malaysia and Indonesia were advised by the international finance community to reduce social support. Only Indonesia followed this advice and cut back on social protection, and experienced a short-term increase in mortality, while Malaysia saw no obvious mortality changes (26). Stuckler *et al* have made a persuasive case for the New Deal and prohibition being responsible for reduced mortality during the USA's Great Depression. (12).
- 2 "Health-related quality of life refers to an individual's perceived physical and mental health and goes beyond the presence or absence of illnesses to encompass a multidimensional concept of wellbeing" (16).
- 3 These developed countries are high, upper-middle and lower-middle income nations as defined by the World Bank (19).
- 4 40 or more cases per 100,000 people.
- 5 High demands at work were measured through questions about monotony, hectic work and having too much to do (39).
- 6 Accounts for government tax and benefit policy announced as of November 2011.
- 7 Work by the Joseph Rowntree Foundation Minimum Income Standard group has been adapted in a London Health Commission report to produce figures for London (51).
- 8 'Poverty' is used throughout this report to refer to 'relative poverty': A household is in relative poverty if its income, after taxes and housing costs, is below 60 per cent of the national median for that year. A household is in absolute poverty if its income is less than a fixed threshold set at the level of the relative poverty line in 2010–11 (40;58).
- 9 This is an estimate of the proportion of households affected by the household benefit cap to a greater extent than the Housing Benefit cap, so the actual proportion is likely to be higher than 11 per cent (59).
- 10 Accounts for government tax and benefit policy to be introduced between 2010/11 and 2014/15 as outlined in the June 2010 'emergency' budget, October 2010 Comprehensive Spending Review and March 2011 budget (52).
- 11 Accounts for government tax and benefit policy announced as of Summer 2011.
- 12 Accounts for government tax and benefit policy announced up to and including the Spending Review, October 2010.
- 13 Accounts for government tax and benefit policy announced up to and including the March 2011 budget.
- 14 A household is in fuel poverty if it needs to spend 10 per cent or more of its income on energy to maintain an adequate level of warmth while meeting other fuel needs (82).
- 15 The Office for National Statistics calculates excess winter deaths as the difference between the number of deaths in December–March and the average of deaths in the preceding August–November and the following April–July (73).
- 16 Fenton A (2011) compared current and future rent estimates for a large number of small London neighbourhoods, taking into account the changes to LHA. Where the local LHA rate is less than the lower quartile of rents, the neighbourhood is considered "largely unaffordable" to LHA claimants, meaning someone will find it difficult to find a property that is available, affordable, in adequate condition and offered by a landlord willing to let to LHA claimants (84).
- 17 Affordable Rent allows properties to be let at up to 80 per cent of the market rent.
- 18 The New Homes Bonus will match-fund the additional council tax raised for new homes and empty properties brought back into use, with an additional amount for affordable homes, for six years from April 2011.
- 19 Exceptions apply if the working person is over 60, or if one of the couple qualifies for the 'disability element' of WTC, is ill, a hospital inpatient or in prison.
- 20 And, if income falls by more than £2500, tax credits will be recalculated for that year, but ignoring the first £2500 of that reduction.



