THE CAMBRIDGE HEALTH GAP

Cambridge Fairness Review

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by Aneirin Jones and Stuart Weir

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FREE FOR PEOPLE ON BENEFITS

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Introduction

This report – the fifth fairness review published by Cambridge Commons - was inspired by the divisions we saw in the daily lives of citizens in Cambridge and the discrepancy between Cambridge's reputation as a prosperous economic powerhouse and the multiple deprivation and shabby living standards in areas of the city.

We decided to investigate further and found evidence of fundamental inequalities in the most basic of all human goods: health. There were devastatingly different outcomes in life expectancy - not just in terms of life expectancy but also of lives lived free of physical illness and disability - and physical and mental health between the richer and poorer wards in the city,. Bluntly, ingrained social and economic inequality harms the health of residents living in deprived areas of Cambridge and prematurely kills or cripples many of them.

This report is not about NHS and local health-care services. The causes of much health inequality, as we will show, lie outside the scope of the NHS. Social and economic factors like income, work (or the lack of it), environment, education, housing, transport and what are today called "life-styles", all affect health and favour the better-off who have greater access to tools which enable them to live healthily.

Our main focus is on Cambridge, but the city is not an island entire unto itself. We are part of a greater whole – the United Kingdom – and beyond, Europe and a global economy. There are two aspects of this unity. First, despite the city's economic surge, we share in the social and economic conditions and divides of the second most unequal country in the western world. More specifically, we will discuss the impact of government policies in our area. The ongoing programme of local government cuts has severely curbed the capacity of our councils to sustain basic services which meet the needs of the local community, to counter deprivation and to improve public health. Another strand of government policy – its unwillingness to control the activities of the corporate food and drink industry – contributes to poor health in and around the city.

It is clear that those who are to blame for the gross inequalities in health that shame our society at large and in Cambridge are the national governments that for the past 35 years have denied the mass of evidence of the root causes of these inequalities – evidence that has accumulated over this period, and that continues to do so. We hope that this report may at least inspire awareness in and around Cambridge of the need for action, and a collective wish to act.

There is much to be proud of in Cambridge's success as an economic and educational powerhouse. But the rhetoric of individualistic success that accompanies so much of Cambridge's achievement – and is indeed pervasive in our national life – stands in the way of the collective effort necessary to eradicate the extreme inequality that

creates the social, economic and health inequalities that disfigure our national life. And which, in Cambridge, plays its part in the alienation and distress in which so many residents live. The 'town and gown' divide persists.

We would have liked also to explore more deeply the prevalence of mental illness, feelings of shame among poor people in Cambridge, especially those on benefits, and the vicious political and media exploitation of popular prejudices against the workless. But we hope to sharpen awareness of the inequities that undermine society in Cambridge and even to inspire a desire for change.

This report is in four parts. First, we review the research findings nationally which have shown over time how social and economic inequality and multiple deprivation leads to harsh inequalities in health. In part 2, we review inequality in Cambridge and describe the difficulties that confront the worst-off people in the worst-off areas. Our conclusion is that spectacular economic growth in the private sector in Cambridge has failed to improve the life chances of a substantial number of residents and that a major drive in public policy is required. Thus in part 3 we review the impact of government activity, austerity policies, with particular attention to social care, housing and public health education.

Finally, in part 4, we focus on the gross inequalities in life expectancy and lives lived free from illness or disability between different areas of the city; and examine links between health inequality and multiple deprivation. And go on to spell out a section of Conclusions.

We should like to thank Tony Jewell, Danielle Mersch and Stuart Tuckwood for their advice and assistance.

Nye Jones & Stuart Weir, July 2016

Part 1
The Causes of Inequalities in Health

It is a common belief that there are simple rules for living a healthy life, if only people could be persuaded to follow them. In 1999, England's Chief Medical Officer published a list of the top 10 tips for good health which have inspired a glut of similar advice from health authorities, GPs, newspapers and magazines ever since. Who doesn't now know they should eat five portions of fruit and vegetables a day?

1. *Don't smoke. If you can, stop. If you can't, cut down.*
2. *Follow a balanced diet with plenty of fruit and vegetables.*
3. *Keep physically active.*
4. *Manage stress by, for example, talking things through and making time to relax.*
5. *If you drink alcohol, do so in moderation.*
6. *Cover up in the sun, and protect children from sunburn.*
7. *Practise safer sex.*
8. *Take up cancer-screening opportunities.*
9. *Be safe on the roads: follow the Highway Code.*
10. *Learn the First Aid ABC; airways, breathing, circulation.*

Good advice, but life in this country is not so simple. Research staff at the University of Bristol have drawn up an alternative list which reflects much of what is known in the UK and internationally about the causes of poor and unequal health

1. *Don't be poor. If you can, stop. If you can't, try not to be poor for too long.*
2. *Don't live in a deprived area. If you do, move.*
3. *Don't be disabled or have a disabled child.*
4. *Don't work in a stressful, low-paid manual job.*
5. *Don't live in damp, low-quality housing or be homeless.*
6. *Be able to pay for social activities and annual holidays.*
7. *Don't be a lone parent.*
8. *Claim all benefits to which you are entitled.*
9. *Be able to afford to own a car.*
10. *Use education to improve your socio-economic position.*

The Bristol list (research-information.bristol.ac.uk) points to the reality of what is known about the causes of persistent inequalities in health in Britain: the massive accumulation of research findings since 1980 which have all confirmed the impact of unequal social class and deprivation on life expectancy and poor and unequal physical and mental health.

In 1980 an expert working party under Sir Douglas Black, President of the Royal College of Physicians, on the causes of ill-health, identified social and economic inequalities as the root of health inequalities, highlighting the "consequences of the class structure: poverty, working conditions and deprivation in its various forms". The report stated that much of the problem of poor health lay outside the scope of the NHS. Social and economic factors and "life style" issues affected health and all favoured the better off. Its two main policy thrusts called for a total and not merely service-oriented approach to health problems; and a radical overhaul of the balance and distribution of resources within the NHS and associated services.

The report met with instant denial by Patrick Jenkin, the Secretary of State in Mrs Thatcher's government:

> I must make it clear that additional expenditure on the scale which could result from the report's recommendations ... is quite unrealistic in present and any foreseeable economic circumstances, quite apart from any judgement that may be formed on the effectiveness of such expenditure.

Ultimately, Penguin Books published a summary of the report (Townsend and Davidson, 1982). Since then the Whitehead Report in 1987, the Acheson Report in 1998 and most recently, the Marmot Review in 2010, have all reinforced the Black Report's findings.

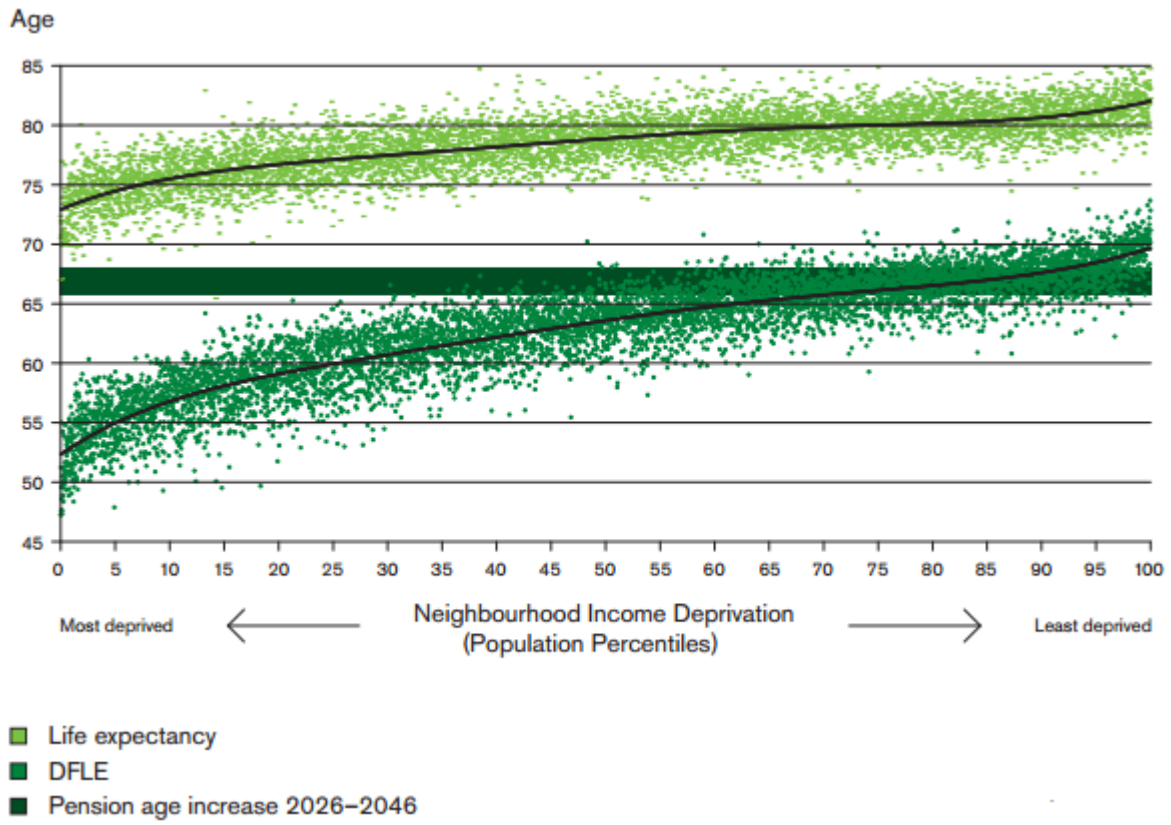
Of course, as the successive reports have made clear, people's health is determined by a complex mix of factors, including family and genetic background, "life-style choices", including smoking, drinking alcohol, obesity and poor diet. But the constant core issues remain: low income, poor housing, working conditions, and obstacles to access to (and the under-utilisation of) health care and other services.

It is now accepted that the significant inequalities in health between individuals and different groups in society are not random. In particular, there is a "social gradient" in health; neighbourhood areas with higher levels of income deprivation typically have lower levels of life expectancy and less long disability-free lives (see Figure 1, opposite); but people's health and life expectancy higher up the income scale are also affected.

This relationship (known as the "Marmot curve") formed an important part of the independent and influential Marmot Review of health inequalities (Marmot 2011 & 2015) which reiterated the same basic message: social and economic inequality harms the health of people living in deprived areas and prematurely kills many of them.

Just as the Black report did, 30 years earlier, the Marmot report emphasised the importance of social and economic equality as being fundamental to health equality and also stated that "Well-being should be a more important societal goal than simply more economic

Figure 1: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics data, 2009

growth". Crucially, the government ignored this aspect of the Marmot report while legislating in 2012 for a major public health response (see Part 3, page 15).

As the Parliamentary Select Committee which scrutinised the then government's response observed, it remained "silent on the need to 'Ensure a healthy standard of living for all', which: would involve establishing a Minimum Income for Healthy Living, and an overhaul of the tax and benefit system, to ensure that "the system as a whole is progressive and avoids financial 'cliff-edges' between employment and unemployment wherever possible."

Part 2
The Unequal 'Cambridge Phenomenon'

As we have seen, inequality & deprivation in all their aspects, nationally (and globally), have a profound negative impact on the physical and mental health of deprived people who live in poorer areas. Cambridge has become a beacon of entrepreneurial success and prosperity over the past 30 years, or more. The question is, has the economic surge in and around the city contributed to lessening deprivation in the city, and to increasing equality; and with it, people's health? Has it increased the obstacles to a good life for worse-off residents? And is it likely to do so in the future?

City in Lead of Britain's Economic Growth

From the 1980s onwards the city and its environs has experienced sustained and accelerating economic growth through private companies specialising in new technology, computing and telecoms, energy and biotechnology, human genome research; and today is enjoying rates of over 7 per cent economic growth. This "Cambridge Phenomenon" derives its power and ideas from the public investment in the outstanding science, medical and engineering research at the University of Cambridge and Addenbrooke's teaching and research complex. The city also benefits from its strategic location and outstanding rail, air and road links.

In 2014, the then Chancellor George Osborne described the ideas driving its growth as being "at the centre of Britain's industrial recovery". In February 2016, *fDi Magazine*, a key publication on global investment opportunities owned by the *Financial Times*, ranked Cambridge at number 10 in a list of top European cities of the future. Patents data are widely used as a proxy to measure innovation; on this measure, Centre for Cities finds, Cambridge is an outstanding No 1 among UK cities, at 101.95 patents per 100,000 population; Aberdeen occupies second place, but way back on 19.7 patents. There is also a high level of business start-ups, at 52 per 10,000 population.

Thus Cambridge is recognised nationally and globally as being at the forefront of Britain's economic growth in a time of relative financial uncertainty, a positive symbol in the midst of austerity. Yet austerity remains a grinding reality for many residents of Cambridge.

Research at the University of Cambridge – and Addenbrooke's – has been at the heart of the city's knowledge-based economy and the surge in knowledge-driven services which provide over 25 per cent of

local employment. The university provides world-class research information and capacity and a large pool of highly-qualified specialists for its workforce. Most critically, the university has done much to sponsor and invest in the entrepreneurial surge. As early as 1970, Trinity College founded the Cambridge Science Park, now home to some 100 hi-tech companies, to take advantage of the university's pre-eminence in science research. The fenced site contains a restaurant, bar, gym and children's nursery alongside office space, labs and research facilities. Trinity's rival college, St John's, set up a 21-acre innovation centre and "business incubator" in 1987 and a ring of similar parks and centres now circles Cambridge.

Cambridge's economic boom has encouraged high levels of migration into the city (and South Cambs) and daily commuting for high-pay jobs, both by train and road into the city and by train out to London. The city is the sixth fastest growing English city. The population is growing at a rate of 1.3 per cent a year; according to one estimate, it was 111,300 in 2002 rising to 126,000 in 2013.

These developments bring problems. House prices and private rent levels have become unaffordable for the majority of inhabitants and there is insufficient social housing to meet needs. The acute traffic density causes severe congestion at rush hours in and around the small city with its narrow roads and archaic layout. Arterial routes into Cambridge are also heavily congested with commuter traffic; frequent incidents and accidents cause inner-city gridlock.

Cambridgeshire county council has failed to produce plans to relieve the burden which is growing with the city's economic growth and the new housing developments that are ringing the city. The traffic causes unhealthy levels of pollution from vehicle exhausts, with notorious hot spots like Elizabeth Way and its often stationery lorries and cars.

A Greater Cambridge City Deal is being pursued under an appointed executive board made up of representatives of the City, South Cambridgeshire and Cambridgeshire County councils, business and the University of Cambridge. Its main purpose seems to be to facilitate still more private sector economic growth, and to deal with the transport infrastructure and congestion, while the Cambridge/South Cambridgeshire local plan provides for a housing surge to build thousands more homes for existing residents and the new workforce. The local plan has not yet been approved.

There is a variety of problematic issues. First, while the intention is clearly to benefit the city region, the City Deal process looks as though it will be imposed on communities from on high, rather

than developed with their participation; and it is not at all clear how legitimate the decision-making board is. Yet it will dominate the politics and resource allocations for the whole region for a generation or more.

Local councils are already staggering under the burden of unremitting budget cuts. The City Deal will not only take place in a context of increasing demand for their other services, but is likely to put those services under more pressure by encouraging more people to move into the region. Effectively, the City Deal is not creating the conditions necessary for good living standards for the existing population and newcomers.

The centrality of economic growth at the heart of the City Deal may very well do nothing to remove the blight of stagnant living standards, multiple deprivation and poverty from thousands of city residents. At a recent meeting organised by Cambridge Commons and Cambridge's Citizen's Advice Bureau, Professor Richard Wilkinson, the epidemiologist and joint author of world-famous book on inequality, *The Spirit Level*, said that experience in Britain since the early 1970s showed that rises in pre-capita GDP and economic development were not reflected in the well-being of the population.

It is, Wilkinson said, the sheer scale of inequality in incomes – the steep rises between groups and individuals – that causes multiple deprivation; and the environmental consequences of a narrow drive towards economic growth had to be born in mind. "We need to grow well-being. We are not here to serve the economy".

Cambridge's Privileged Social Caste

The economic surge has made several entrepreneurs, new and old, filthy rich. Among those who have made it into the top 1 per cent and the *Sunday Times* Rich List for 2015 are Mike Lynch of software company Autonomy, Hermann Hauser of Acorn, hedge fund manager Ewan Kirk and Jonathan Milner of Abcom.

But the most significant outcome has been the creation of a prosperous professional, academic and managerial class in and around the city. The proportion of "knowledge workers" in Cambridge is very high by national standards, with 61 per cent of the working population classified as "professional, managerial or technical" workers. By comparison the national figure is 44 per cent. The "Cambridge phenomenon" has spilled over into neighbouring South Cambridgeshire where the same cohort makes up 57 per cent of the working population.

Cambridge is thus home to a highly privileged caste with very high and rising incomes, raising average earning figures in the city well above the national median. This caste lives in high quality housing with wine cellars in many homes; pays for extensive private schooling in the south of the city; enjoys high standards of education; pursues an active associational life with a host of cultural choices; and can turn to fast trains to and from London.

Cambridge's two-thirds professional and managerial class forms a hegemonic social cliff which the middle and working class population and poor inhabitants cannot ascend. Connectivity, or social "bonding" is almost wholly confined within the ranks of the privileged class and its formal and informal networks; and there is no sign of a healthy "bridging" social capital between classes and groups.

The Social Divide

Symbolically, the Science Park lies adjacent to East Chesterton and King's Hedges wards in the city. They are two of the poorest areas in Cambridge. The people who work in the centre drive or cycle into the fenced enclosure. It is a short walk from the centre of innovation and affluence to its deprived surroundings. But they are worlds apart.

Cambridge is a relatively small city in the second most unequal country in the western world. Of course, Cambridge is not an island entire unto itself. The city experiences the same fast growing social and economic inequality that is tearing the country apart. Official Social Exclusion Unit reports have spelled out the consequences, warning that the poorest neighbourhoods have tended to become more rundown over the last generation; and that "The risks of social exclusion are not evenly shared, but concentrated in the poorest individuals and communities."

In February 2016 the Social Mobility and Child Poverty Commission revealed that Cambridge ranks among the country's bottom 20 per cent of local authorities in terms of prospects for its poorer children.

Alongside the knowledge-based elite there is another Cambridge, with a middle income and working class population living on depressed earnings and experiencing insecurity in their employment and homes. The gulf between Cambridge's richest and comfortably off residents and the city's poorer people is huge: the median income for all households in Cambridge in 2014 was £31,800 per annum; the median income for the lowest quartile of households – i.e., the bottom 25 per cent – was less than half that, at £15,700 a year.

At a time of stringent austerity policies, the "trickle-down" theory that the benefits of economic growth trickle down to benefit lower classes from *en haut* rings hollow in the much-feted Cambridge economic surge. Multiple deprivations and social exclusion disfigure the north and east of the city. Many residents live in old and damp housing, which they rent from private landlords or own. More and more residents are being forced out of the city altogether by the high costs of buying and renting. Homelessness is rising steeply. Homeless applications to the City Council rose from 112 in 2011-12 to 146 in 2014-15. Last year in the first three quarters of the year 143 households were accepted as homeless. The figures have also risen in South Cambridgeshire. Rough sleeping is on the increase. Many must turn to state benefits (often when "working hard" in low-paid employment) and even to the Cambridge food bank.

A significant proportion of poorer households live in poorer wards in the north and east of the city - Abbey, Arbury, East Chesterton and King's Hedges and where deprivation is concentrated (see our report, *Cambridge: Wealth and Want*, for more information). Whereas small neighbourhoods in wards like Castle, Newnham and Queen Edith's are among the 20 per cent least deprived areas in the country, two neighbourhoods in King's Hedges are among the 20 per cent *most* deprived. And 18 more such neighbourhoods in Cambridge's other poorer wards like Abbey and Arbury are among the 40 per cent *most* deprived, in the country. These are the areas in which low pay is concentrated and deprivations of all kinds exist.

It is rarely understood that low and middle incomes in Britain are intertwined with the benefit system. There is no line between people who "do the right thing" and go to work and those who depend on the welfare system. Of necessity, not choice, thousands of Cambridge residents do both.

In late 2014, 7,204 households received Housing Benefit to assist them to pay otherwise unaffordably high rents; some 4,900 Cambridge families, with 7,500 children, received working and/or child tax credits. Cambridge also has a significant caseload of people with disabilities or chronic illness who are on benefits, 6,340 in all in May 2014: 3,820 were on Disability Living Allowance; 380 people were on Personal Independence Payments, and 2,140 were on Attendance Allowance for elderly people.

A total of 5,110 households, 5.5 per cent of the population, were on out-of-work benefits: Job Seekers Allowance (JSA), Employment Support Allowance (ESA), Income Support and Incapacity benefits.

Child poverty is prevalent in the city; on average, one in seven children (13.9 per cent) lived in low-income families in 2013,

according to official statistics published in September 2015. In the city's poorest areas, the incidence of child poverty was very high. Nearly a quarter of all children in King's Hedges (23.6 per cent), in Abbey (21.5 per cent) and East Chesterton (21.1 per cent) lived in poverty (see Table 1 below). The figures are almost certainly worse now. The consequences for the children's overall health, education and well-being are likely to be very bad.

Table 1: Child poverty in Cambridge, by ward

Ward	**Children in low income families, %**
King's Hedges	23.6
Abbey	21.5
East Chesterton	21.1
Arbury	18.1
Trumpington	13.7
Cherry Hinton	13.4
Romsey	10.4
Coleridge	10.2
Petersfield	8.8
Queen Edith's	7.9
Castle	5.3
West Chesterton	4.5
Newnham	4.1
Market	3.4
Average	**13.9**

Source: HM and Revenue and Customs, Personal tax credits statistics

Entitlement to benefits is set at subsistence levels – that is, income levels at which individuals and households can afford only to pay for essentials. As there are allowances for children, families with children do receive larger benefits to meet the subsistence costs of looking after children – giving them higher incomes than working families. But the larger sums paid are still calculated at subsistence levels only. Households in and out of work can also claim Housing Benefit to assist them in paying rents which are rising fast to unaffordable levels; and obviously families with

children who rent have to pay for larger, and thus more expensive, accommodation.

The government has imposed a "benefit cap" of £500 weekly for couples or people with children (£350 for single childless claimants) who receive state benefits. As Lady Hale, the deputy president of the Supreme Court, said: "The prejudicial effect of the cap is obvious and stark. It breaks the link between benefit and need. Claimants affected by the cap will, by definition, not receive the sums of money which the state deems necessary for them adequately to house, feed, clothe and warm themselves and their children."

The further government cap – the Local Household Allowance - on the proportion of rent paid by Housing Benefit bites particularly severely in Cambridge with its high private rents and is set well below the level of such rents. The cap reduces families' benefit to below subsistence levels and makes it harder to find landlords willing to let to tenants who depend on benefit. High rents also drive low-income families out of Cambridge and force them to commute.

Some 14,600 people aged over 65 are believed to live in Cambridge (2,021 are over 85) and nearly one in five are likely to be poor. Cambridge has a higher level of "fuel poverty" than the regional and national averages (see Part 3, page 19). The increasing scarcity of access to publicly funded social care has a very severe effect on older people (see Part 3, page 17). Many young people in Cambridge struggle, as elsewhere. In 2104, the Work Foundation commented that "even in cities with successful economies, the rate of youth unemployment remains far too high", naming Cambridge as one such.

As an absolute backstop, workers over 25 rely on the national minimum wage, £7.20 an hour, now misleadingly designated officially as the National Living Wage; those under 25 qualify for a rate of £6.70 an hour or less. But £7.20 is anything but a true "living wage" as it is not based on living costs; it was introduced to under-cut the voluntary living wage of £8.25 an hour outside London (£9.40 an hour in London). Some 15 per cent of workers in Cambridge earn less than the true living wage. Cambridge Commons advocates that the voluntary London living rate should be paid in Cambridge with its high living costs.

Moreover, the national minimum wage is frequently evaded. It is not possible to determine how pervasive evasion is in Cambridge. But we can judge how seriously Her Majesty's Revenue and Customs agency takes its responsibility to police the NMW. The agency has not prosecuted a single employer in Cambridgeshire for failing to pay the NMW for the past five years.

Poverty is a Life Sentence

People in Cambridge on benefits, whether they are in or out of work, are seriously poor. Otherwise they would not qualify. Many rely on benefits because of other needs: poor health, disability, incapacity or multiple disadvantage. Thus a significant minority of residents are severely disadvantaged. The incidence of debt is rising; in late 2014, the Citizen's Advice Bureau was dealing with over a 1,000 people in debt. The service says, "in many case notes, the client's understanding of issues and ability to handle daily tasks was so low that it is highly likely they had undisclosed mental health issues." That year the CAB's senior debt adviser said that in 25 years' working on debt he was for the first time unable to balance his clients' income and expenditure. In other words, it was beyond him – as it was beyond them.

The benefits system wreaks havoc with the lives of many people who rely on it. Benefit levels reduced below subsistence needs, its complexity, maladministration and delays in payments, constant errors and demands, its intricate rules, the punitive sanctions regime, fit-for-work tests, intrusive questioning, huge bills to recover benefit overpayments, suspicion and fraud allegations, compound the insecurities and deprivations of poverty. People are often left with no money for weeks at a time, becoming dependent on the food bank, on the Cambridgeshire Local Assistance Scheme, and above all on friends and family.

The damage that poverty – and the benefits system – inflicts on the lives of Cambridge's poor and disadvantaged citizens is revealed in microcosm in a CAB report on foodbank claimants in 2014-15 in September 2015. This report, on 274 households that the service referred to the city's foodbank for food or fuel vouchers, has identified links between deprivation and damage to mental and physical health in the city.

The troubled lives of the worst-off people who live in the city's worst-off neighbourhoods are starkly revealed. Four out of five households were out of work, most of whom had to rely on basic state benefits which were the main cause of their immediate troubles. Three quarters (76.6 per cent) needed food or fuel vouchers because of benefit delays, refusals of benefit advances and other benefit issues. Only two households were in full-time work, the other working households were in part-time or zero hours work or low-income self-employment.

Social policy analysts have known for some time that the precarious nature of life on low incomes can have an adverse effect on the mental and physical health of poor people. Stress, strains and

anxiety, the prevalence of debt, the fear of a sudden emergency that can plunge a family into financial disaster, and the stigma of poverty, all combine to place an intolerable burden on people for whom there is no prospect of escape into an easier life. Since 2010, the complexity of new and punitive benefit rules, sudden punishments that simply cancel their benefit payments, and the growing public mood against "scroungers" – mostly people on benefits – has intensified the pressures on the poor.

The CAB report provides some evidence of the adverse health effects of poverty and life on benefits in Cambridge. Of the reasons for applying for food bank assistance, "sickness" is recorded as the cause in 126 cases – that is, nearly half of the total (45.9 per cent). The report suggests that 31 per cent of the households receiving assistance from the food bank present "mental health issues", and 26 per cent have physical health problems. The report expresses alarm about the prevalence of mental health problems among its caseload of vulnerable households, saying that "we suspect that the number of people with health issues is under-reported"; and draws attention to the number of people with ill-health who require food vouchers.

We ought not to under-estimate the severity and complexity of "handling daily tasks" on benefit. In 2015, the Cambridge Commons report, *Cambridge: Wealth and Want*, spelled out the difficulties of coping with complex and changing benefit rules and the practicalities of their administration, stating ultimately that negotiating their lives "is a life sentence of bumping in and out of crisis, as either their situation or the rules change in ways beyond their control; as money starts and stops and brown envelopes arrive, containing letters often hard even for benefit advisers to understand."

Cambridge CAB maintains an advisory service at the East Barnwell Health Centre in a deprived part of Abbey ward. Wendy Eyles, their worker there, describes the effects of stress in the lives of the people she advises on money, benefits and housing difficulties, with panic, anxiety and depression evolving into mental health issues; "it is not just the problem that I am asked to advise on, there are layers of problems. For me it is just like peeling an onion".

Part 3
Deprivation and Public Policy

Spectacular private sector growth has failed to shift the enduring inequalities between different groups and areas in the City. Given the role of multiple deprivation as the driver of inequalities in health, the onus lies on public policy, national and local, to combat deprivation and invest in people's lives, homes, education, skills and work prospects. This should be done in partnership with the private sector, universities and the public, but much more than that, it must be done – and it is not being done.

Public policy in and around Cambridge is dominated by the government's priorities. Cambridge City Council, Cambridgeshire County Council and other local authorities are largely the creatures of government dictates and policies. They have none of the constitutional protection against the centre which is common in other European countries. They have scarcely any independent income and rely almost wholly on government funding. George Osborne has year after year cut the central government grant on which they rely, thus forcing the councils to make cumulative damaging "savings". The Chancellor and other ministers determine and dictate local authority policies, interfering down to the smallest details. Thus policy priorities and funding that could be framed to meet the needs and wishes of local communities, and are tailored to local circumstances, are overridden by the government cuts and the austerity regime.

In Part 3 we examine five aspects of public policy action in and around Cambridge:

- the government's austerity-driven national spending cuts and tax policies and practice as they apply in Cambridge, South Cambridgeshire and Cambridgeshire;
- the consequences and inherent risks of the enforced "savings" in social care, social housing and housing repair;
- the effects on housing needs of current benefits policy (also discussed in Part 2, pages 11,12);
- the ability of our councils to impose a 40 per cent share for affordable housing in local housing developments; and finally
- the effects of the government's policy on public health in Cambridgeshire.

The consequences for people suffering multiple deprivation in and around Cambridge are clear, even without the knock-on effects of Brexit on the country's finances. The likely effect of Brexit on a

poorer British economy means that austerity policies will continue for decades and multiply and health inequality will grow.

The Government's Spending Noose

Inequality in Britain has been rising fast for more than a generation. The level of income inequality among the UK population has been well above the OECD average in the last three decades. The effects of inequality have been exacerbated over the past six years by government austerity – the series of sustained reductions in public spending that initially aimed to bring the UK budget deficit to an end by 2015-16. Two years ago the austerity programme was extended to at least 2018. After Brexit,it will survive for longer.

Behind the object of overcoming the national budget deficit, the government has had an accompanying aim - to reduce the size of the welfare state by freezing and reducing state benefits and drastically reducing local government spending. Unequal tax policy has hit the poorer part of the population hardest: taking the system as a whole, including regressive VAT as well as income and property taxes, the poorest tenth of households has paid 43 per cent of their income in tax, while the top tenth paid 35 per cent. While in other western countries, increases in income tax have played an important role in deficit reduction, in the UK fiscal consolidation is driven by cuts in services and benefits.

Our local authorities are undergoing unprecedented budgetary challenges. These challenges are affecting services for a majority of the population and its most deprived sections. The link between deprivation and ill-health and life expectancy means that government action is harming both the health of the people of Cambridge and of the nation as a whole. Ambiguities in official responsibilities and the boundaries of deprivation obscure its ultimate political accountability.

Local authorities rely almost entirely on central government grant, since they have minimal revenue-raising resources of their own and there are severe political restrictions on raising the regressive Council Tax which anyway, structured as it is, produces poor returns. The City, South Cambridgeshire and County councils must therefore cut their spending following diminishing government grant down to ZERO in 2019:

- In January 2016, Cambridge City Council announced £589,000 in "savings" for 2016-17, as part of an overall savings target of £4.2 million during the next five years. Government financial

support to the City Council for 2016-17 was reduced by £1.06 million, a reduction of 15 per cent. The reduction in the central grant settlement since 2010-11 has been 53 per cent.

- South Cambridgeshire District Council has made approximately £5.5 million in savings to meet cuts in their central government grant and predicted that the grant would be cut completely by 2018-19. The grant was £7.8 million in 2010-11.

- Cambridgeshire County Council has announced that a total saving of over £100 million will be required within the next five years, including a predicted £41 million during 2016-17. These figures are predicated on the basis of continuing reductions in central government grant and the need to find an extra £19.7 million to allow for inflation, other charges and required savings. Overall, government grant has been cut from £111 million in 2010 to £39 million this year and to ZERO in 2019. Since 2009, the County has cut a total of £218 million from its spending.

In announcing the projected saving of £100 million, the County Council stated that "With the gap increasing between demand for services and the funding available Cambridgeshire will inevitably be faced with even more cuts in the future." The then Leader of the Council said that they had "reached a tipping point where frontline services will be further affected."

The Human Costs of the "Savings"

As Stephen Crabb, said on his appointment as Work and Pensions Secretary, "behind every statistic there is a human being". Here we consider the consequences of two government policies, real and potential, for local people: the effect of the cuts to social care, for adults, children and families, in Cambridgeshire; and the damage government cuts and contradictory housing policies are doing, and will do, to people in need of decent and affordable homes in Greater Cambridge and dealing with unfit and dangerous housing.

1. Social Care: the Silent Catastrophe

David Plank's reports on social care, published by the Cambridge Commons, set out the full devastating consequences of the enforced cuts from the County Council services (*Social Care: from Crisis to Catastrophe* and the update in January 2016, *Social Care: the Silent Catastrophe*).

Cuts in social care are not like potholes in the road, obvious to everyone. They harm people's lives, health and well-being behind four walls, hidden from public view. Here is a summary of the effects of the savings decided in Cambridgeshire over the past two years:

- *Older people* are having their incontinence pads changed less often, receive less help with their personal toileting – making distressing incontinence more likely – and less help with washing and bathing. The home care service has been reduced significantly and 15 minute visits are taking place. Carers, many of them elderly, are often exhausted and their health is adversely affected;

- *Adults with mental ill-health* are less able to get a much needed residential place; and receive less home care and other community support, including advocacy – leading to their deterioration, distress and heavier burdens on carers;

- *Adults with learning difficulties* receive crisis care only, with reduced help to live an independent normal life – and less help to get and keep a job;

- *Adults with physical or sensory disabilities* are less able to live independently, with more isolation and loneliness due to less opportunity to go out;

- *Children and young people in the council's care* are at greater risk of grooming, exploitation or abuse; greater risk of future mental health issues, homelessness or prison; and they receive less independent contact, personal support and advocacy due to pressures on social workers who are supposed to be there for them. And this for children and young people for whom the state, through the County Council, has parental responsibility. Of these young people, about 60 per cent have emotional and mental health problems; and the main reason for entering care is abuse or neglect (62 per cent);

- *Children, young people and their families in need* receive less social work and other skilled support when they are in difficulties and at risk of deterioration or breakdown. The devastation of the Youth Service, including complete cessation of dedicated youth work with disaffected young people who are not in touch with mainstream services. The children's centres budget in 2014 was reduced by one quarter, requiring the loss of skilled staff, including family workers. It is no surprise that the number of children and young people in care has increased by 100 to 570 over the last two years, having been stable at 470 over the previous ten. The cuts in preventative services are one important factor in this;

- *Families with children with disabilities* under pressure due to the strain and needs of the child or young person get reduced support and less much-needed respite, increasing the risk of family breakdown.

All the adults above who are adversely affected have recognised critical or substantial care needs. The children and young people affected are categorised as requiring a service without which they

are unlikely to achieve a "reasonable standard of health or development", or where "significant impairment" of that standard would otherwise occur, or as "disabled", i.e., substantially and permanently handicapped by a physical or mental condition. Life for poorer and vulnerable children is being made worse by huge cuts in the county's children's centres, to £2.5 million from £6.3 million in 2014.

In addition there is the overall human cost of introduction *tighter gatekeeping and rationing mechanisms* across the board. So fewer people are assessed as eligible for services or personal budgets. Those who are assessed as eligible get a reduced service, a poorer quality service or have it reduced or withdrawn before it would have been previously.

2. The Health Impact of Cambridge's Poor Housing

Recent public health reports for Cambridge identify two areas where the city has significantly high rates of adverse health conditions, compared with England as a whole: *fuel poverty* and *injuries due to falls and hip fractures among people aged 65 and over.* Both of these are associated with Cambridge's private older housing stock, whether in owner occupation or rented.

Fuel poverty is driven by low income. It is determined by the interplay of household income, energy costs and the energy efficiency of the property; the term "fuel poverty" describes the situation where a household's energy costs are disproportionately high, forcing them to choose between heating their homes or going without food and other essentials.

Fuel poverty accounts for some 2,700 deaths a year in England and Wales. In Cambridge, the number of "excess deaths" over the three years, 2010-2012 amounted to 160, or 53 a year on average. Living in a cold home has detrimental effects on physical and mental health, particularly respiratory and cardio-vascular disease. There is some association between cold homes and truancy, anti-social behaviour and poor educational achievement.

Some 12 per cent of Cambridge residents suffer from fuel poverty, only Luton in eastern England has a higher rate. In older housing in deprived enclaves in the city – in wards like Arbury, Market, Petersfield and Romsey - the rate increases to 20 per cent, or one in five homes. (In South Cambs, the worst area was in Milton.)

Clearly, the rise in energy costs, stagnant incomes and adverse benefit changes have had an impact on the ability of low-income households to afford heating bills. But there is also a root cause of the high rates of fuel poverty: the high proportion of non-decent housing stock, at 5.63 per cent, and the city's legacy of older

unimproved housing. Some 31 per cent of Cambridge housing dates back to before 1919 (the national average is 23.5 per cent).

The City Council is a partner in the Cambridgeshire Action on Energy Scheme, promotes the County's collective energy switching scheme and has had a government grant to pursue a Green Deal targeted home insulation scheme. Amid a plethora of ameliorating, joint working, liaising, anti-poverty and informative schemes, the Environmental Health Department, the City's key agency responsible for housing standards, seems essentially to play only a "working with landlords" role. It is not clear whether the resources or political will necessary to deal with fuel poverty are in place.

Further, the rate for emergency admissions to hospital after falls in people aged over 65 is significantly higher in Cambridge than the national average. The average annual number of admissions is 446,130 among men and 300 among women. It seems likely that the standard of the housing stock is a contributory factor. Official data include "fall hazards" in 5,189 properties in the private sector, 14 per cent of the total.

3. A Government U-Turn on Affordable Homes for Rent

Decent, affordable and secure housing is the foundation stone of a life free from deprivation. Such housing, usually in the public sector with the council or housing association, is the ultimate protection for lives that may otherwise be consumed by poverty, disadvantage, insecurity and ill-health.

The great majority of people living on middle or low incomes in Greater Cambridge – i.e., in the City and South Cambridgeshire district council areas – cannot afford to buy their own home or to rent privately. House prices and rent levels are far higher than the national average and are rising fast. Private renting may be in crowded and/or non-decent properties and is increasingly insecure.

In addition, there are just over 4,100 applicants on the two councils' housing registers. Homelessness is rising fast in the City and South Cambs. In the first three quarters of last year 143 households were accepted as homeless by the City. Low and middle income people are being forced out of the City in search of housing as gentrification gains pace.

Providing affordable homes for rent in the City is therefore vital for the health and well-being of households on middle incomes who cannot afford "intermediate housing" as well as poor families. More social housing is therefore an urgent priority. But the government has long been engaged on a destructive blitz on the ability of Cambridge City Council to build and retain affordable social housing.

Yet in a sudden contradictory reversal, in negotiations over devolution for the region, the pre-Brexit government yielded significant concessions on its housing policies to gain a settlement on its devolution scheme. The government has offered £170 million for new housing "at affordable rent" and shared ownership in Cambridge and South Cambridgeshire – £70 million of which will be spent solely on new City Council properties.

Cambridge has struggled to build 131 new council homes since 2010 and a further 164 are likely to be completed in the coming year. According to a report in the *Cambridge News* (18 June), leading City councillors believe the injection of funds could potentially deliver more than 500 new council homes over the next five years. But given the complexity of the finances, this belief is open to question.

Councillor Kevin Price, Cambridge City's Executive Councillor for Housing, said on the Labour Party Camaraderie site, "The £70 million ant will build over 500 new council homes in Cambridge, replacing all lost to Right to Buy to 2020 and will make a significant and rapid contribution to meeting housing need and for homeless families in the city. Over time, the extra rents will also enable us to build even more new homes." He also hailed the commitment of £100,000 million new affordable housing association rental and shared ownership homes in Greater Cambridge.

This is an important improvement. A tribute to the council's tenacious negotiating effort is due. But the funds are for five years only and the contribution has to be set against the huge unmet need for affordable housing locally, and the likely continuity in adverse government housing policies (see below).

4. The Blitz on Social Housing

It remains to be seen how this reversal in what was fixed government policy will work out in practice under a post-Brexit administration. Up to May 2016, the government was committed to wrecking the City's ability to retain existing social housing; created obstacles to the City's ability to deliver new homes; was forcing housing associations to give their tenants the right to buy their social homes; continued the right of council tenants to buy social homes from the City; and was set to force the council to sell off more council homes.

The tally of measures to cut and obstruct keeping and building social homes in Greater Cambridge was likely to destroy the existing community. An official report to the City's Housing Scrutiny Committee on 8 March set out the complex cat's cradle of government decrees, obstacles, funding rules and the council's efforts to find a way through to defending and building affordable homes (*The*

Housing Market in Greater Cambridge, access to affordable housing and the roles of the councils, 250216.pdf, www.cambridge.gov.uk).

Apart from the damaging cuts to Cambridge's services, the report found:

- The government requirement to make an annual 1 per cent cut in all social rents would reduce Cambridge's Housing Revenue Account (HRA) by £15 million over four years. The council was completing a programme of 280 new social rented homes and 217 for sale, but the report warned that the government decree would "put on hold any further development of affordable housing". The requirement is not about making life easier for tenants, but to save government money on housing benefit.
- The impact of retaining the Right to Buy council homes, its extension to housing association tenants – and the sale of High Value council properties to pay for the extended policy – would drastically reduce the availability of affordable housing for rent. In all, Cambridge would lose some 170 social homes for rent a year; and South Cambridgeshire some 100.

The report analysed the government's housing programme and found "no commitment to new general needs affordable rented housing". In addition, scarce affordable housing land would be lost to the new commitment to provide and subsidise starter homes, officially recognising them as affordable, while the truth is that in Greater Cambridge, they will only provide homes for those on higher incomes. The report also demonstrated that shared ownership homes were also out of reach for many.

Two other government reforms will disturb access to housing and create harmful social disturbance, thus making it more important than ever that the council provides affordable housing. The Local Housing Allowance (LHA) rates for eligibility for Housing Benefit are considerably lower than private sector rents across Greater Cambridge. Rising private rents, combined with a four-year freeze on LHA rates, lowering the overall cap on benefits, and other welfare cuts, will make it even more difficult for lower income households to access private renting. The LHA for people aged under 35 creates major problems as it is set at a shared accommodation rate, much lower even than for council one-bed flats.

The details of the second reform – the new Pay to Stay policy raising social rents up towards market levels for better off council tenants – are not yet clear. The government is making it compulsory for councils to raise the rents of all households earning £31,000 or more. In Cambridge and South Cambs private rents are at least double those of socially rented homes. The council estimates that a household on £30,000 a year would have to pay 61 per cent of their take-home income in rent for a three-bedroom house in Cambridge (45 per cent in South Cambs) if required to pay full market rent.

As the City's report comments, "this policy has the potential to displace hard working families. It also has implications for people with carers, for children attending local schools, and for the economy if lower paid workers are forced out of their homes."

5. Developer Evasion of Affordable Housing Targets

Hearings on the Joint Cambridge & South Cambridgeshire Local Plan, which is yet to be approved by the Inspector, have often witnessed angry debate on the role of developers in providing much-needed homes locally. The joint local plan aims to continue a quota of 40 per cent affordable housing for the majority of schemes, with lower quotas in South Cambs for smaller schemes.

Developers chafe at this requirement, arguing forcefully that it puts the "viability" – i.e., profits - of schemes at risk. The councils find it desperately hard to maintain quota levels, especially as the larger developer companies pursue aggressive legal challenges to them and usually win. The position is further complicated by the government's changed definition of "affordability" and weakening the ability of local councils to prevail by fudging the argument on "viability".

An investigatory article by Jon Vale in the *Cambridge News* (31 May) showed what is at stake. He revealed that 1,178 affordable homes had been "lost" on development sites in the two council areas over the past three years. Some 1,000 affordable homes have been lost at Northstowe, the 10,000-home new town at the former Oakington barracks. This development now has planning permission with only 20 per cent affordable housing for 3,500 homes in phase two of the development.

In the heart of Cambridge, the Grand Central 143-home luxury development near the railway station on Rustat Road will provide a paltry eight affordable units. The original commitment by Persimmon, the country's largest house builder by volume, to build 30 per cent affordable housing on the site was cut to 6 per cen. Sales income at the site, now being built by Weston Homes, is set to be at least £17 million higher than originally forecast by Persimmon. Its senior managers are being rewarded with a £600 million bonus pot (*Cambridge News*, 20 June).

6. Curtailing Preventative Public Health Work

Cambridgeshire County Council took on responsibility for improving public health under the 2012 Health and Social Care Act and its transfer from the NHS Primary Care Trust. No other policy area

addresses health inequalities so directly. Public health initiatives seek to bring about societal changes, encouraging and enabling people to make choices which will improve their quality of life. Tackling obesity, reducing smoking and drinking, providing sexual health advice and undertaking preventive campaigns, for example, in the workplace and on health issues are all part of the public health remit.

The change-over involved the creation of a national quango, Public Health England, the appointment of a local Director of Public Health with a health and well-being board and a ring-fenced public health grant for the two years, 2013-14 and 2014-15. The grant for Cambridgeshire in 2015-16 was set at £35 per head, significantly below the national average of £51 per head.

The 2012 reform package was partly inspired by the Marmot review (see Part 1). The government announced that "Public health funds have too often been raided at times of pressure in acute NHS services and short-term crises". The shift to local authorities was supposed to protect the funding while the government worked "to re-balance the focus on the causes of ill health and ensure that public health funding is prioritised and not squeezed by other pressures, for example NHS finances, though it will still be subject to running cost reductions and efficiency savings."

However, the weaker link between NHS Commissioners and providers following the transition risks moving public health back to the pre-1974 days of working in isolation from the NHS. Arguably public health in England is fragmented between Public Health England, local authorities, GPs, mental health trusts, acute hospitals and university public health departments.

The Cambridgeshire package soon unravelled. Almost at once funding was cut *because* public health was moved from the NHS. In June 2015, George Osborne announced £200 million of in-year "savings" to the public health budget for the year, amounting to 6.2 per cent cut for each local authority; and that autumn went further, imposing average annual real-terms "savings" of 3.9 per cent in the public health system over the following five years. A deft piece of work, shifting responsibility from the NHS and intense scrutiny to local authorities which are vulnerable to cuts and yet will take the rap under local and often different party political leadership. The reality for Cambridgeshire is that the region's health was affected and the NHS had to pick up much of the bill.

However, Cambridgeshire's business plan, released prior to Osborne's 2015 changes, also announced a series of "savings" in the budgets for smoking cessation services, sexual health and dental public health and an additional £367,000 was also required from public health commissioned services, non-pay costs and agency staff.

These savings were made to address "demography and inflation pressures" and a freeze in the public health grant up to 2016.

Following further national cuts in rate support, the County Council was forced to review numerous elements of their public health budget, essentially putting a stretched service under greater pressure. In December 2015, the Council announced a figure of £2.7 million in public health service cuts for 2016-17, replacing the previous requirement of £500,000. This was followed by detailed proposals for how the cuts would be made, which were released in a draft business plan for public health in January 2016.

Members of Council's Health Committee subsequently examined the cuts, expressing concern that they would jeopardise their preventative health strategy for tackling the causes of ill-health before problems developed in seriousness and had to be dealt with by the NHS. They stated that the cuts were "ill-advised because they will result in higher long term health costs" and "expressed frustration at the absurdity of being asked to make major cuts to prevention work." Similarly, Simon Steven, chief executive of NHS England, has stressed the need for prevention in the community as well as within the NHS if the NHS five-year plan is to be delivered.

Cambridgeshire's prevention work includes a number of core functions to improve the health of the local community, from organising and paying for regular health checks for local people, protecting people from communicable diseases and environmental threats, organising and paying for sexual health services, organising height and weight checks for primary school children, and assessing the needs of the local population and investing in the improvement of specific health areas. Its business plan for 2015-16 announced a focus on key areas of mental health, transport related health issues and areas of health inequality, including

- Reducing smoking prevalence through investment in regional collaboration for tobacco control. (Smoking is a major cause of the health inequality between different social groups and areas. There is evidence from elsewhere in the UK of the impact and cost effectiveness of reducing smoking prevalence, and preventing cancers, respiratory conditions and heart disease. Smoking is far more prevalent in disadvantaged communities.)
- Workplace health support: Increased support to employers across the county to improve and maintain the health of their workforce, and especially manual workers.

The members' concerns tally with widespread discontent at a national level regarding recent government policy. The Faculty of Public Health estimated that the initial £200 million cut could result in an eventual cost to the NHS of over £1 billion.

PART 4
Life expectancy in Cambridge

Life expectancy – and the quality of that life – are the most striking measures for determining inequalities in the health of a given population. The figures for life expectancy in Cambridge have been calculated across the city's 14 wards (see Table 1). The latest data for 2010-14 reveal a shocking gap in life expectancy of 11.3 years between people who live in Newnham – 89.5 years – and people in King's Hedges, who die on average at the age of 78.2 years.

Table 1: Cambridge City life expectancy at birth by ward 2006–2010 and 2010–2014 (persons)

Ward	Life expectancy, persons 2006–2010	Ward	Life expectancy, persons, 2010–2014
East Chesterton	77.7	King's Hedges	78.2
King's Hedges	78.6	East Chesterton	79.9
Coleridge	79.2	Coleridge	80.0
Trumpington	80.3	Romsey	81.1
Abbey	80.6	West Chesterton	81.6
Petersfield	81.6	Arbury	82.4
Romsey	81.6	Trumpington	82.5
Arbury	81.6	Abbey	83.7
West Chesterton	82.2	Cherry Hinton	84.5
Market	82.8	Petersfield	84.6
Queen Edith's	83.3	Market	84.8
Cherry Hinton	83.8	Queen Edith's	86.0
Castle	85.0	Castle	86.2
Newnham	88.2	Newnham	89.5
Average	81.9	**Average**	83.2

Source: Cambridgeshire County Council Public Health Intelligence, using data from the Health and Social Care Information Centre Primary Care Mortality Database and Osmalffice for National Statistics mid-year population estimates

These figures present stark evidence of the health gap between the inhabitants of different areas of our city.

The life expectancy figures in Table 1 also show a steady and distinct "social gradient" downwards between the wards. The life chances of people living in more prosperous wards, like Castle (86.2 years) and Queen Edith's (86 years) are far superior to those of inhabitants of Romsey, Coleridge and East Chesterton, at 81.1, 80 and 79.9 years respectively.

As Table 1 also shows, life expectancy has increased incrementally across the board, but the gap is not closing down between the richer and poorer wards. If anything, it widens slightly – for example, if you compare King's Hedges and Arbury with Market. We regard Newnham as an "outlier", because life expectancy as high as 89 years could hardly increase significantly, though it still rises further than in King's Hedges over the same period.

Measuring Multiple Deprivation

Given the mass of evidence described in Part 1, it will be no surprise that deprivation plays a significant role in the differences in life expectancy between the wards in Cambridge. We expose the differences between Cambridge's more prosperous and poorer areas more acutely by presenting the variations in life expectancy between the city's 14 wards along with their average scores from the Index of Multiple Deprivation (IMD) in England. This official index (see Table 2) measures the relative deprivation of areas in England that are smaller than wards, known as Lower Layer Super Output Areas (LSOAs). The data we present here (see Table 3 below) have been averaged out to produce ward level figures.

Table 2: Weighting for Indices of Multiple Deprivation (IMD) score

Domain of deprivation	Contribution towards IMD score (%)
Income	22.5
Employment	22.5
Education	13.5
Health	13.5
Crime	9.3
Barriers to housing and services	9.3
Living Environment	9.3

Source: Department of Communities and Local Government, English Indices of Deprivation 2015

The Index measures and weighs deprivations in incomes, work, health, disability, education, training, poor environmental and housing conditions, and barriers to public services, with supplementary attention given to the effects of low incomes on children and elderly people. The percentage weightings for the factors involved in creating an IMD score are shown in Table 2.

While it may seem to treat health as a relatively small aspect of deprivation, the significance of the index lies in the fact that all the factors in Table 2 are related to health outcomes. The well-being of any population rests on close links between the inter-relating areas which must be seen as a whole. Thus, rather than health being isolated from the economic and social factors in deprivation, the index actually reflects the weight of the analysis from the Black to Marmot reports (see Part 1) on the relationship between physical and mental health and issues like economic poverty, poor housing, lack of education, clearing the way for action on the components of deprivation and health.

Life Expectancy and Multiple Deprivation

As table 3 opposite shows, while the relationship between the ranking of wards by life expectancy and the incidence of multiple deprivation in the wards is not absolute, there is a strong and obvious correlation between life expectancy and multiple deprivation. The higher the deprivation score, the greater the deprivation on the ground.

The scores for multiple deprivation reveal glaring differences in the quality of life across Cambridge and a significant spatial division between south Cambridge and the north and east areas of the city. The gap between the best-off and worst-off wards is huge: once again Newnham is the best-off, with the lowest average score, at 6.1, and King's Hedges is again the worst-off, at 27.2. The IMD scores, however, also give us a more nuanced understanding of the complexities of deprivation in and between wards, reflecting the mixed living conditions in comparatively prosperous wards and indicating a larger gap in quality of life, for example, between East Chesterton and Coleridge than the life expectancy figures might suggest.

The significant differences between the small subsets of wards in Cambridge, the LSOAs, within both well off and poorer wards can be shown by looking at the most deprived LSOAs in the city. More recent IMD data from 2015 for Cambridge contain 68 of these subsets of wards, consisting of about 1,200 households each. Overall the data show that the general quality of life in Cambridge is improving, with the city having an IMD local authority rank of 227 compared to a rank of 188 in 2010.

Table 3: Cambridgeshire Multiple Deprivation (IMD) scores; average life expectancy 2010–2014: Cambridge City wards

Wards (most deprived to least deprived)	Multiple Deprivation average scores, 2010	Life expectancy, persons, 2010–2014
King's Hedges	27.2	78.2
Abbey	25.3	83.7
East Chesterton	23.3	79.9
Arbury	20.8	82.4
Petersfield	15.7	84.6
Trumpington	15.3	82.5
Romsey	15	81.1
Cherry Hinton	14.2	84.5
Coleridge	13.7	80
West Chesterton	12.1	81.6
Market	11.4	84.8
Queen Edith's	8.8	86.0
Castle	7.5	86.2
Newnham	6.1	89.5

Sources: Indices of Multiple Deprivation 2010, Department for Communities and Local Government, Cambridgeshire County Council Public Health Intelligence, using data from the Health and Social Care Information Centre Primary Care Mortality Database and Office for National Statistics mid-year population estimates

The data also show that the ten most deprived LSOAs in Cambridge are concentrated in the north and north-east of the city, although often alongside significantly wealthier LSOAs. As stated in Part 2, two LSOAs, both located in the Abbey ward, fall into the 20 per cent most deprived areas nationally. Both of these have become more deprived since 2010. Two other LSOAs in Abbey and Arbury have also become more deprived.

One of the consequences of Cambridge's economic boom is the growing process of gentrification within the city, a trend that is being accentuated by austerity policies and house prices and market rents driving poorer people out. Thus there is clear potential for significant change in the populations and social environment of formerly deprived areas.

Whether this change will benefit the poorer residents of these areas is problematic, particularly when the data show that some Cambridge LSOAs have deteriorated markedly, suggesting a worrying concentration of vulnerable residents in increasingly deprived

conditions. But there is the further issue of the social separation between classes, even in close proximity.

Good and Poor Health in Cambridge

We have taken life expectancy as our ultimate measure for examining inequalities in health, but the quality of that life is a very significant issue of concern. The healthy living statistics for 2011, released by Cambridgeshire County Council (see Table 4 below), broadly follow the figures for inequalities in life expectancy shown in table 1 (see page 26). Once again, people in Newnham enjoy the best health, over 90 per cent of residents report that they are in good or very good health, and well under one in ten (7.5 per cent) report poor or very poor health. King's Hedges is the worst-off ward: with fewer residents in good or very good health (82.6 per cent) and nearly one in five in poor or very poor health. Overall, in Cambridge, more than one person in ten (11.8 per cent) experiences poor or very poor health.

Table 4: Experience of poor or very poor health, 2011

Residents by ward	In poor or very poor health (%)
Newnham	7.5
Market	9.6
Castle	9.7
Queen Edith's	10.2
West Chesterton	10.4
Petersfield	11.2
Trumpington	12.3
Cherry Hinton	14.1
Coleridge	14.4
Romsey	14.6
Arbury	15.2
East Chesterton	15.9
Abbey	17.3
King's Hedges	17.4

Source: Office for National Statistics, Census 2011. Age-standardised percentages calculated by Cambridgeshire County Council Public Health Intelligence

These figures show how much our first criterion - life expectancy – is a crude instrument for measuring inequalities in health. The

effects of multiple deprivation on the lives of the people who experience it wreak severe damage and distress day on day (see Part 2 above and *Cambridge: Wealth and Want*, Cambridge Commons 2014). But the cruellest effect is perhaps the damage it does to their physical and mental health during their lifetime, as it diminishes the very quality of their years of life.

There is broadly an 8 per cent difference between the numbers who feel in good health between poorer and more prosperous wards. But this figure is based on the average scores for the population as a whole. However, analysis of the figures broken down by age group shows just how pernicious the effects of deprivation are. Residents in the poorer wards begin to ***feel in poor or poorer health*** at much younger ages than those in richer areas.

If we look at the scores by age group we see that:

- At ages 35-49, the proportion of Cambridge residents who feel in good health is on average ***10 per cent lower*** in the poorer areas (King's Hedges, Arbury and East Chesterton) than in the prosperous wards like Market and Newnham;
- At 50-64, the difference is even greater. The scores for good health in Newnham and Market are 90 and 84 per cent; whereas East Chesterton scores 71 per cent, Arbury 72 per cent and King's Hedges 67 per cent. That's a staggering ***23 per cent difference*** in the proportions of people in good health at a relatively young age between a rich (Newnham) and poor (King's Hedges) area;
- At 65-75 the gulf remains very large. Newnham, at 81 per cent, and Market, at 78 per cent, are far healthier areas than East Chesterton, Arbury and King's Hedges, at 61, 63 and 60 per cent respectively. Thus the good vs poor health gap across the city stands at ***over a 20 per cent***;
- At 75-84, the gap begins to close as people age further but the residents in rich areas remain healthier. The figures for good health in Newnham, at 63 per cent, and in Market, at 54 per cent, are not as distant from those for Abbey, 40 per cent, East Chesterton, 48 per cent, Arbury, 44 per cent, and King's Hedges, 42 per cent, but the gap is still significant.

The evidence that living in a poorer area means you are far more likely to feel in poor health at a younger age than if you live in a richer area is undeniable. In Newnham, the proportion of people with a long-term health problem or disability is 7.8 per cent, and in Market just under one in ten, at 9.9 per cent; whereas in poorer wards the proportions are higher, at 15.7 per cent in King's Hedges, 15.5 per cent in Abbey, 14.4 per cent in East Chesterton, and 13.9 per cent in Arbury.

It is not clear from the figures whether any significant measure of mental and psychological well-being forms part of the overall picture.

Premature mortality

An accompanying indicator of inequality in health is premature mortality. Statistics show that people in more deprived wards tend to die at a younger age.

The figures for Cambridge are again shocking, and show that you are three or four times more likely to die prematurely if you live in a poorer area of the city such as King's Hedges or Arbury than in a more prosperous ward like Market or Newnham. As Tables 5a-5c indicate, this gulf is not closing.

Table 5a: Under 75 all-cause mortality, males, average deaths per year

Ward	2008–2010	2010–2012	2012 – 2014
Newnham	3	3	3
Market	8	7	4
Arbury	15	15	13
King's Hedges	16	18	19

Table 5b: Under 75 all-cause mortality, females, average deaths per year

Ward	2008–2010	2010–2012	2012–2014
Newnham	3	2	2
Market	3	1	3
Arbury	7	7	8
King's Hedges	13	10	12

Table 5c: Under 75 all-cause mortality, all persons, average deaths per year

Ward	2008–2010	2010–2012	2012–2014
Newnham	6	5	5
Market	11	8	8
Arbury	22	21	21
King's Hedges	29	28	31

Source: Health and Social Care Information Centre Primary Care Mortality Database, Cambridge ward selection

Summary

The situation in Cambridge regarding health inequality is complicated, with a range of factors impacting on the statistics for different wards. Gentrification is clearly having an impact, as wealthier incomers are displacing poorer residents in even the most deprived wards. People do not remain static in the same way that ward boundaries largely do. Yet there is still an unmistakable division within Cambridge, between the health outcomes of residents in deprived areas and those in the least deprived parts of the city.

This is made all the more troubling when we consider the vast amount of money which is being poured into offices, infrastructure projects and luxury apartment buildings in and around the city. The answer to health inequality in Cambridge must be to improve the quality of life in the poorest wards, not through gentrification but through investing in the people who are already there.

Economic growth is a very unequal phenomenon.

Conclusions
A matter of life and death

The shocking gaps in life expectancy and lives free of disability or illness between people living in the richer and poorer wards in Cambridge are an indictment of the unequal society to which we have all become too accustomed. The knowledge that life expectancy in Cambridge is very much less unequal than in most other areas of the country compounds the shameful record of successive governments. As we have shown, both the scale of health inequalities, the root causes and the measures necessary to remove them have been made plain to Conservative, Labour and coalition government time and time again over the past 35 years.

The root causes of inequalities in health were conclusively identified in the 1980 Black Report, and have been reprised several times since: the pervasive class-based social and economic inequalities of society at large, poverty, poor housing, educational disadvantage, working conditions, deprivation in its various forms, the poorer environment in Britain's worst-off areas, and neglected "life style" issues.

Residents of Cambridge, a small city which has benefited from enormous economic growth over most of the intervening period, must reflect on how its growing wealth, economic and academic resources have enriched some two thirds of the population without improving the quality of life for the other third. Moreover, the consequences of this economic surge have sharpened the basic inequalities that afflict the worst-off people and places more severely than richer citizens – unaffordable house prices, rising private rents, for example, and suffocating and poisonous congestion on the city's roads.

It is extraordinary that the current City Deal project for the city unashamedly aims to improve the transport infrastructure to facilitate further private sector economic growth and business; and commuter links and further housing development for the anticipated business and university workforce.

The scandal is not simply that the project is so unbalanced, doing little for the "have-nots" and harming the home environments of many residents and poisoning the wider environment still more. It is also that at the same time national austerity policies impoverish ordinary people, in and out of work, and especially vulnerable state beneficiaries; and further impoverish our local authorities, making it impossible for them, for example, to provide adequate social care and decent affordable homes or to improve poor and aged housing in which many residents suffer or die because of fuel poverty.

It is true that the government has yielded a one-off concession on social housing to the City Council, not in recognition of the need to remedy its relentless bias against council homes, but as a sop to secure its proposals for a regional authority and elected mayor.

This concession is testament to the City Council's tenacious resolve to maintain and expand its housing stock for the benefit of people in housing need. But it would be fruitless to suggest that there is any point in making recommendations in this report that ultimately add up to the abandonment of a government austerity regime that is designed not only to reduce the national deficit but to create a small state.

The Marmot review in 2010 emphasised that social and economic equality was fundamental to health equality, stating that "Well-being should be a more important societal goal than simply more economic growth". Crucially, the government ignored this aspect of the Marmot report while legislating in 2012 for a major public health response (see Part 3, page 15).

As the Parliamentary Select Committee which scrutinised that response observed, it remained "silent on the need to 'Ensure a healthy standard of living for all', which: would involve establishing a Minimum Income for Healthy Living, and an overhaul of the tax and benefit system, to ensure that the system as a whole is progressive and avoids financial 'cliff-edges' between employment and unemployment wherever possible."

Final thoughts. The Black report in 1980 called for a "total and not merely service-oriented" approach to health problems; and a radical overhaul of the balance and distribution of resources within the NHS and associated services. We are still waiting.

Our researches demonstrate that local authorities can make a big difference in health outcomes through vigorous public health policies and effective social care. It is outrageous that local authorities throughout the UK are prevented from making this difference because they lack the constitutional status that should make them able to make their own policies, free of central dictation and meddling, and in command of their own resources rather than financial subservience to central government.

The central importance of public health policies requires governments to adopt a strong co-ordinated food policy across all departments to counter-act the growing plagues of obesity, diabetes and other chronic diseases and deal with the so-called "life style" issues that make a significant contribution to health inequalities. Such a policy should be underpinned by action to control the harmful products of the food and drink industry.

The Cambridge Commons

We are a new organisation for progressive-minded people in and around Cambridge. We are affiliated to the national charity, The Equality Trust, and we provide a network for Compass.

This report is the fifth in our fairness review of Cambridge. We have previously published a report, *Wealth and Want,* on poverty and deprivation in the city; two reports on the damaging cutbacks in social care in Cambridgeshire; and report on social housing in the city. Printed reports are available for £10 each and they are also on line.

We organise public meetings. We recently organised a protest meeting on the City Deal, in cooperation with the Federation of Cambridge Residents Associations, to make the case for the inclusion of social justice in its proposals. Last year we organised a major conference advocating a modern Magna Carta for the UK.

We have three priorities:

- To make local people aware of the poverty that exists in and around Cambridge and to bring people together to campaign *for* the living wage; *against* the precarious low wage economy; and to *end* the punitive benefits system which is causing hunger and misery to thousands of residents.
- To campaign *for* a more equal society and *against* the rising tide of inequality here and in the country as a whole.
- To draw attention to the absurd cruelty of a housing market that prevents ordinary citizens here from buying or securely renting their own homes, unless their circumstances are so desperate that they qualify for social housing.

There is conclusive evidence on a large range of criteria - e.g., physical and mental health, standards of education, incidence of crime and violence, family stability – that greater inequality has adverse effects across the whole of society and harms richer people alongside the poor. Further, inequality does substantial harm to the economy, as the OECD has demonstrated.

We have and will share a positive belief in a communal response to this country's difficulties in place of the neo-liberal economic and anti-state policies that are now supreme. We stand for a public realm of common citizenship in place of divvying up public services and institutions between private owners. **We believe that fairness and a spirit of co-operation between self-confident citizens is the way forward for our society.**

Membership of Cambridge Commons is free and open to all, but we would be grateful for donations so that we can do more. Check us out on our website - if you wish to join us, you can do so via the website.

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