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Article

Inequalities in mental health and well-being in a time of austerity: Baseline findings from the Stockton-on-Tees cohort study

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ABSTRACT

Since 2010, the UK has pursued a policy of austerity characterised by public spending cuts and welfare changes. There has been speculation – but little actual research – about the effects of this policy on health inequalities. This paper reports on a case study of local health inequalities in the local authority of Stockton-on-Tees in the North East of England, an area characterised by high spatial and socio-economic inequalities. The paper presents baseline findings from a prospective cohort study of inequalities in mental health and mental wellbeing between the most and least deprived areas of Stockton-on-Tees. This is the first quantitative study to explore local mental health inequalities during the current period of austerity and the first UK study to empirically examine the relative contributions of material, psychosocial and behavioural determinants in explaining the gap. Using a stratified random sampling technique, the data was analysed using multi-level models that explore the gap in mental health and wellbeing between people from the most and least deprived areas of the local authority, and the relative contributions of material, psychosocial and behavioural factors to this gap. The main findings indicate that there is a significant gap in mental health between the two areas, and that material and psychosocial factors appear to underpin this gap. The findings are discussed in relation to the context of the continuing programme of welfare changes and public spending cuts in the UK.

Background

Following the collapse of the global financial markets in 2007, the initial months of 2008 witnessed the US and European governments entering into an unprecedented public rescue package for the banking sector (Gamble, 2009). This followed concern that whole national economies would collapse – and indeed the financial crisis resulted in the longest period of global recession in the post-war era (Gamble, 2009). The common European response to the ensuing increase in national debt and increased unemployment has been the new *politics of austerity*, which has seen widespread programmes of public spending cuts (Kitson, Martin & Tyler, 2011). Subsequently, since 2010, the UK government has pursued the implementation of lower public spending and market led growth to reduce the national deficit. Public services, investment in public infrastructure and expenditure on welfare have been significantly reduced (Kitson et al., 2011).

Previous research has shown that such significant changes in the economy can have important negative implications for population health and inequalities in health with increases in suicides, rates of mental ill health and chronic illnesses (Barr, Taylor-Robinson & Scott-Samuel, 2012; Stuckler & Basu, 2013). Unemployment increases during economic downturns and is itself strongly associated with greater morbidity and mortality (Bambra, 2011), particularly mental health problems, such as depression and stress (Janlert, 1997; Hagquist, Silburn, Zurbrick, Lindberg & Ringbäck, 2000), suicide and suicide attempts (Platt, 1986; Newman & Bland, 2007; Lewis & Sloggett, 1998). Recessions are also characterised by an increase in job insecurity and 'precarious' employment, both of which are associated with higher rates of stress, and mental ill-health (Ferrie, Shipley, Stansfeld & Marmot, 2002).

Studies have found however, that there are important national policy variations in the effects of recessions and economic downturns on population health. For example, Stuckler and Basu (2013) found that the population health effects of recessions vary significantly by policy context with those countries (such as Iceland and the USA) which responded to the financial crisis of 2007 with an economic stimulus, faring much better – particularly in terms of mental health and suicides – than those countries

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(e.g. Spain, Greece and the UK) which chose to pursue a policy of austerity. Similarly, Hopkins (2006) found that in Thailand and Indonesia, where social welfare spending decreased during the Asian recession of the late 1990s, mortality rates increased. However, in Malaysia, where no cut-backs occurred, mortality rates were unchanged (Hopkins, 2006). Similarly, Stuckler, Basu, Suhrcke, Coutts and McKee (2009) study of 26 European countries concluded that greater spending on social welfare could considerably reduce suicide rates during periods of economic downturn.

Further, the economic effects of austerity are not distributed evenly within a country or population, either spatially or socially. Within the UK, some areas (such as the north-east of England and more deprived local authorities) have experienced greater public budget reductions and been more affected by changes to welfare benefits than others (Beatty & Fothergill, 2016). This has disproportionately impacted on the availability of key services in these areas, widening social inequalities within them and spatial inequalities between them and other areas (Pearce, 2013; Bambra & Garthwaite, 2015). Health inequalities are intimately linked to social inequalities and so a widening of social inequality, as a result of austerity, *may* lead to a further exacerbation of social and spatial health inequalities. This of course also includes inequalities in mental health.

However, there has been little research to date into the effects of austerity on health inequalities and most of it has mainly focused on the effects at a national population level (Suhrcke & Stuckler, 2012). There have been little consideration of the effects on health inequalities at the regional or local levels (Bambra, 2013). There is particularly a gap in terms of the effects on inequalities in mental health. This paper is the first to address this gap in the literature by exploring local inequalities in mental health and wellbeing during a time of austerity via a case study of the local authority of Stockton-on-Tees, a local authority in the North-East of England. It is also the first UK study to empirically examine the relative contribution of material, psychosocial and behavioural factors to inequalities in mental health. The primary aim of the research is to establish the magnitude of inequalities in mental health and wellbeing, and the role of different explanatory factors (material, psychosocial, and behavioural) in explaining it, between people living in the most and least deprived areas of the local authority within the context of austerity.

Inequalities in mental health and mental wellbeing

There are ongoing debates around how we conceptualise both mental health and mental wellbeing. Huppert (2009) argues that mental well-being incorporates feeling good (hedonic well-being) and functioning effectively (eudaimonic wellbeing). Whilst feeling good involves aspects such as happiness, interest in life, confidence and engagement, functioning effectively is about having a sense of purpose, feeling in control of life, and the ability to create positive relationships. Mental health and wellbeing can be seen as a pathway through which determinants of health, including deprivation and poverty, impact on physical health. Alongside this, however, they also need to be seen as outcomes in their own right, not just as mediators of this relationship between deprivation and physical ill-health (Rogers and Pilgrim, 2003).

Both physical and mental health follow a social gradient; the more advantaged people are in social and economic terms, the better their health (Scrambler, 2012). There are particularly large gaps between the extremes of the social hierarchy with people from the highest socio-economic backgrounds living longer (on average 7 years) and with longer amounts of their life disability-free (on average 17 years more) than people from the lowest socioeconomic backgrounds (Marmot, 2010). Alongside the link between socioeconomic class and physical health, the link between social deprivation and mental health is also well-established (Williams, 2002). A person's mental health is shaped by the environment he or she is living in (Curtis & Jones, 1998), and as such it is also of importance to consider the complex interactions between places and the people living in them, and their resulting impact on health. Significant gradients and health gaps also exist between areas with differences of up to 9 years in life expectancy between the most and least deprived areas of the UK (ONS, 2015).

Poor mental health is both a cause and a consequence of social inequality. The social consequences of living in poverty, including the impact of unemployment, underemployment, debt, poor living conditions, and living in areas with high levels of deprivation, can increase vulnerability to developing mental ill-health (Pilgrim & Rogers, 1999). Additionally, people who are experiencing mental distress, and those who have been labelled with mental health problems, are at increased risk of poverty, due for instance to risks around discrimination in the workplace preventing people from being able to secure and maintain employment (Evans-Lacko, Knapp, McCrone, Thornicroft & Mojtabai, 2013). Further, welfare changes as a result of austerity have disproportionately affected disability and ill-health related benefits, effectively bringing about a reduction in incomes for people who are unable to work as a result of ill-health.

Explaining health inequalities

Three main theories have been documented to account for health inequalities: materialist, psychosocial, and behavioural/cultural (Bartley, 2008).

Materialist explanations

Materialist explanations of health inequalities focus on the relationship between social structure and health, linking ill-health with the distribution of resources and inequalities in power (Williams, 2003). Material determinants factors include income, employment and level of education, and factors relating to the physical environment, such as poor quality housing and living in areas with high levels of deprivation, crime, and pollution. Cohort studies have linked poorer health with poverty, unemployment, and low income (Bartley, 2008).

Psychosocial explanations

Psychosocial explanations of health inequalities introduce the concept of relative deprivation: “What matters is where we stand in relation to others in our own society” (Wilkinson & Pickett, 2010: 25), placing emphasis on how people experience inequality and the emotional response to it which can give rise to acute and chronic levels of stress. Over time stress has an impact on the body, leading ultimately to physical and mental ill-health (Marmot & Wilkinson, 2006).

Behavioural explanations

Behavioural accounts of health inequalities focus on the things individuals do that are damaging to their health, and how certain groups of people are more likely to engage in health-damaging behaviours. So, for instance, smoking, drinking alcohol, poor diet and lack of exercise have all been found to be more prevalent amongst people from deprived areas than affluent ones (Marmot, 2010). Consumption of high amounts of alcohol appears to be a