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Article

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

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ABSTRACT

In response to the 2007/8 financial crisis and the subsequent 'Great Recession', the UK government pursued a policy of austerity, characterised by public spending cuts and reductions in working-age welfare benefits. This paper reports on a case study of the effects of this policy on local inequalities in mental health and wellbeing in the local authority of Stockton-on-Tees in the North East of England, an area with very high spatial and socio-economic inequalities. Follow-up findings from a prospective cohort study of the gap in mental health and wellbeing between the most and least deprived neighbourhoods of Stockton-on-Tees is presented. It is the first quantitative study to use primary data to intensively and longitudinally explore local inequalities in mental health and wellbeing during austerity and it also examines any changes in the underpinning social and behavioural determinants of health. Using a stratified random sampling technique, the data was analysed using linear mixed effects model (LMM) that explored any changes in the gap in mental health and wellbeing between people from the most and least deprived areas, alongside any changes in the material, psychosocial and behavioural determinants. The main findings are that the significant gap in mental health between the two areas remained constant over the 18-month study period, whilst there were no changes in the underlying determinants. These results may reflect our relatively short follow-up period or the fact that the cohort sample were older than the general population and pensioners in the UK have largely been protected from austerity. The study therefore potentially provides further empirical evidence to support assertions that social safety nets matter - particularly in times of economic upheaval.

1. Background

In response to the 2007/8 financial crisis and the subsequent 'Great Recession', the UK government pursued a policy of austerity, characterised by public spending cuts and reductions in working-age welfare benefits. This paper reports on a case study of the effects of this policy on local inequalities in mental health and wellbeing in the local authority of Stockton-on-Tees in the North East of England, an area with very high spatial and socio-economic inequalities. This paper presents follow-up findings from a prospective cohort study of the gap in mental health and wellbeing between the most and least deprived neighbourhoods of Stockton-on-Tees. It is the first quantitative study to use primary data to intensively and longitudinally explore local inequalities in mental health and wellbeing during austerity and it also examines any changes in the underpinning social and behavioural determinants of health – the *pathways* potentially linking austerity with health inequalities.

1.1. 'Great Recession' and Austerity

The global financial crisis of 2007/8 led to a long period of recession across Europe. The catalyst for the slump was a downturn in the USA housing market which led to a massive collapse in financial markets across the world. Banks increasingly required state bailouts, stock markets posted massive falls which continued as the effects in the 'real' economy began to be felt with high unemployment rates of around 8.5% in the UK and the USA, 10–12% in France and Italy and more than 20% in Spain and Greece. The IMF announced that the global economy was experiencing its worst period for 60 years: the 'Great Recession' (Gamble, 2009). Government responses to the recession varied, in the

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UK (like a number of other countries most notably Spain or Greece), a strict policy of austerity was implemented from 2010 onwards (Kitson, Martin, & Tyler, 2011). This has been characterised by a drive to reduce public deficits via large scale cuts to central and local government budgets, reduced funding for the health care system, and large reductions in welfare services and working-age social security benefits. In a comparative European study, Reeves, Basu, McKee, Marmot, and Stuckler (2013) found that the UK austerity policy was the third most extensive.

It is estimated that the UK welfare reforms enacted up to 2015 will take nearly £19bn a year out of the economy. This is equivalent to around £470 a year for every adult of working age in the country. The biggest financial losses arise from reforms to incapacity-related benefits (£4.3bn a year), changes to Tax Credits (£3.6bn a year) and the cap of 1 percent up-rating of most working-age benefits (£3.4bn a year) (Beatty & Fothergill, 2014). The 2010–2015 Housing Benefit reforms resulted in more modest losses – an estimated £490 m a year arising from the under occupancy charge (most commonly referred to as 'bedroom tax'), for example – but for the households affected the sums are nevertheless still large (e.g. £12 per week reductions per 'spare room' for those on benefits that are only around £65 per week) (Moffatt et al., 2016) (for more details see Bambra and Garthwaite, 2015; Bambra, Garthwaite, Copeland, & Barr 2015). Research shows that these welfare cuts – alongside the steep reductions in local government budgets of up to 40% - have hit the poorest parts of the country the hardest (Beatty & Fothergill, 2016): austerity 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 and Garthwaite 2015; Bambra et al., 2015, Schrecker and Bambra, 2015). These 'reforms' have also disproportionately impacted on low income households of working-age (Browne & Levell, 2010) whilst, in contrast, pensioner households have been more protected by, for example, the universal state pension 'Triple Lock' (a guarantee to increase the state pension every year by the higher of: inflation, average earnings or a minimum of 2.5%) and other universal allowances for the elderly such as the winter fuel allowance (Green et al., 2017).

1.2. Health inequalities

It is well documented that there are significant inequalities in health by socio-economic status. For example, in England, men and women living in the most deprived neighbourhoods have a life expectancy of 9 and 7 years less respectively than those living in the least deprived (ONS, 2014). There are similarly stark inequalities in mental health with, for example, suicide and self-harm rates considerably higher in the most deprived neighbourhoods (Cairns, Graham, & Bambra, 2017). Baseline analysis of the Stockton-on-Tess cohort also found a significant gap in mental health and wellbeing between the most and least deprived areas (Beckfield & Bambra, 2016; Mattheys et al., 2016; Bambra, 2016; Farrants et al., 2016).

These health inequalities are intimately linked to broader social and economic inequalities and so a widening of inequality, as a result of austerity, may lead to a further exacerbation of social and spatial health inequalities. There are three main *pathways* linking socio-economic status and health: materialist, psychosocial, and behavioural/cultural (Bartley, 2016; Skalická, Lenthe, Bambra, Krokstad, & Mackenbach, 2009). The materialist explanation focuses on income and on what income enables – access to goods and services and exposures to material (physical) risk factors (e.g. poor housing, inadequate diet, physical hazards at work, environmental exposures). Cohort studies have linked poorer mental health with poverty, unemployment, and low income (Bartley, 2016). Psychosocial explanations focus on how social inequality makes people feel – domination/subordination, superiority/inferiority, social support, demands and control – and the effects of the biological consequences of these feelings on health. Cohort studies have shown that over time stress has an impact on the body, leading to physical and mental ill-health (Marmot & Wilkinson, 2005). The behavioural explanation considers the association between socio-economic status and health to be a result of health-related behaviours as a result of adverse personal/psychological characteristics or because unhealthy behaviours may be more culturally acceptable amongst lower socio-economic groups (Bartley, 2016; Skalická et al., 2009). Consumption of high amounts of alcohol appears to be a particular risk factor for mental ill health – whilst other behavioural factors such as smoking have a more nuanced relationship (WHO and Calouste Foundation 2014). The baseline analysis of the Stockton-on-Tess cohort found material and psychosocial factors to be the most important determinants of inequalities in mental health (Beckfield & Bambra, 2016; Mattheys et al., 2016; Bambra, 2016; Farrants et al., 2016).

1.3. Recession, austerity and health

The short term overall population health effects of recessions are rather mixed with the majority of international studies concluding that all-cause mortality, deaths from cardiovascular disease and from motor vehicle accidents and hazardous health behaviours *decrease* during economic downturns, whilst deaths from suicides, rates of mental ill health and chronic illnesses *increase* (Bambra, 2011). Following the 2007/8 crisis, worldwide an excess of 4884 suicides were observed in 2009 (Corcoran, Griffin, Arensman, Fitzgerald, & Perry, 2015) and over the next 3 years (2008–2010) an excess of 4750 suicides occurred in the USA, 1000 suicides in England, and 680 suicides in Spain. Areas of the UK with higher unemployment rates had greater increases in suicide rates (Hawton, Bergen, & Geulayov, 2016). There is also evidence of other increases in poor mental health and wellbeing after the 'Great Recession' including self-harm and psychiatric morbidity (Barnes et al., 2017; Vizard & Obolenskaya, 2015).

However, the effects of recessions on health and health inequalities vary by country – with more negative trends in mental health and wellbeing in those countries, including the UK, that implemented austerity (Stuckler & Basu, 2013; Basu, Carney, & Kenworthy, 2017). Following the 2008 recession, Greece, Italy and Spain imposed cuts in health and social protection budgets. These countries experienced worse health effects when compared to countries such as Germany, Iceland and Sweden who opted to maintain social safety nets over austerity (Stuckler & Basu, 2013; Helliwell, Huang, & Wang, 2017). Similarly, Karanikolos et al. (2013) found that across Europe, weak social protection systems increased the health and social crisis in Europe. Whilst there are few quantitative studies of the effects of austerity on health inequalities in the UK or elsewhere, initial studies such as that by Barr, Kinderman, and Whitehead (2015a) suggest that inequalities in mental health and wellbeing increased at a higher rate between 2009 and 2013. Further, people living in more deprived areas have seen the largest increases in poor mental health (Barr et al., 2015b) and self-harm (Barnes et al., 2016). Internationally, Niedzwiedz, Mitchell, Shortt, and Pearce (2016) found that reductions in spending levels or increased conditionality may have adversely effected the mental health of disadvantaged social groups. These are in keeping with previous studies of the effects of public sector and welfare state contractions on increases in health inequalities in the UK, Finland, US and New Zealand in the 1980s and 1990s (Bambra, 2016; Bambra et al., 2015; Copeland et al., 2015; Kokkinen, Muntaner, & Kouvonen, 2015; Farrants et al., 2016).

The existing research literature therefore suggests: (1) health inequalities are linked to social inequalities; (2) the importance of social