

## Pulling in different directions?

The impact of economic recovery and continued changes to social security on health and health inequalities in Scotland

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# Selected glossary of terms

<b>Term</b>	<b>Definition</b>
Claimant count unemployment	Adults who are eligible for and claim unemployment benefit (Jobseeker's Allowance), recorded by administrative data.
Conditionality	The principle of making access to and continued receipt of benefits contingent on claimants' behaviour, e.g. for job seekers, on whether they are considered to be 'actively seeking work'.
Disability Living Allowance (DLA)	A benefit for disabled people who need help with mobility or care costs. It is gradually being replaced by Personal Independence Payment (PIP) for people aged 16–64.
Employment Support Allowance (ESA)	The main benefit for working-age adults who are not working due to long-term health conditions or disability in the UK. Claimants must undergo a Work Capability Assessment (WCA) before they can claim ESA. Successful claimants are placed in either the work-related activity group (WRAG), on a lower rate of benefit and with more conditions attached to continuing to claim, or the support group, with a higher rate of benefit.
ILO unemployment	Adults who meet the International Labour Organisation definition of unemployment, reported through the Labour Force Survey: out of work, able to start work in the next two weeks, and had either looked for work in the past four weeks or were waiting to start a job they had already obtained.
Involuntary part-time working	Part-time workers reporting that their reason for part-time working is because they could not find a full-time job.
Involuntary temporary employment	Temporary workers reporting that their reason for working in a temporary job is because they could not find a permanent job.

<b>Term</b>	<b>Definition</b>
Jobseeker's Allowance (JSA)	The main benefit for working-age adults who are unemployed, available for and actively seeking work.
Mental health problems	Adults with a score of 4+ on the 12-question General Health Questionnaire (GHQ-12).
Personal Independence Payment (PIP)	A benefit for working-age adults with long-term health conditions or disability to help meet some of the extra costs they face. From 2013, it replaced Disability Living Allowance (DLA) for new claims from working-age adults. Existing working-age DLA claimants are being reassessed for PIP between 2015 and 2017.
Probable suicide	Deaths coded as 'intentional self-harm' or 'event of undetermined intent'.
Relative poverty	Living in a household where incomes are less than 60% of median incomes, net of housing costs and housing benefits, adjusted for the size and composition of the household.

# Executive summary

The purpose of the social security system is to offer a degree of income protection for population groups who cannot work (such as children and pensioners) and working-age adults who are not currently working or whose incomes are insufficient to sustain independent living.

Income has a fundamental influence on health inequality. Changes in income, whether due to changes in the economy and labour market or the social security system, therefore have the potential to impact on health and health inequalities. Monitoring developments in these factors in parallel can help improve our understanding of health.

This report is an update of the baseline report *Making a Bad Situation Worse?*, published in October 2013. It provides an update on developments in the social security system and changing economic context, monitors changes in population health and health inequalities, and presents findings from a rapid review of the literature to identify whether and which subgroups of the population have been disproportionately affected by the social security reforms.

## Changes to social security

Since the publication of the baseline report, changes have continued to be implemented to the working-age social security system. Some information is available on the outcomes of these changes for Scotland:

- Since June 2011, the Work Programme in Scotland has delivered more than 38,000 job outcomes.
- Universal Credit (UC) began to be piloted in Scotland in December 2013. By March 2015, before rollout to the rest of Scotland began, there were 880 people on the UC caseload.
- Personal Independence Payment (PIP) started to replace Disability Living Allowance for new claimants from April 2013.
- Stricter conditionality was introduced for people claiming Jobseeker's Allowance (JSA) in October 2012 and Employment Support Allowance (ESA) in December 2012. By March 2015, more than 94,000 people in Scotland had been sanctioned under the new regime.

The Smith Commission made a number of recommendations on devolving responsibility for some aspects of working-age social security to the Scottish parliament. These included some aspects of the administration of UC; benefits for carers, disabled people and those who are ill; and delivery of employment programmes.

Announcements in the July 2015 Budget represent an intensification of social security reforms (freezing working-tax credits, reductions in the value of ESA), partly mitigated by increasing the value of the national minimum wage for the over-25s, with mixed results predicted for low-income households to 2020.

## Economic trends

The UK recession officially began in the spring of 2008 and ended in the summer of 2009, but recovery in output and the labour market took far longer. Economic output in Scotland had almost returned to levels seen in 2007 (pre-recession) by 2013. Female employment rates had, by 2014, returned to pre-recession levels; male employment rates had yet to do so.

Levels of temporary and involuntary part-time working have fallen since 2012/13. However, in 2014 there were still 50,000 more people in Scotland working part-time because they could not find a full-time job, and 15,000 more in temporary employment not by choice, than in 2007. Self-employment rates, which increased steeply in the recession, have been stable since 2012.

The number of working-age people claiming out-of-work benefits has fallen back to pre-recession levels, though there were still more than 400,000 working-age adults claiming key out-of-work benefits in Scotland in 2014.

Around 40% of the unemployed are not claiming JSA, increasing to almost 60% among young adults; this partly reflects a gap that opened up in the mid-to-late 1990s, following the introduction of JSA, but may also reflect recent policy changes, especially increased conditionality. This may mean that a growing number of unemployed people are not receiving financial support or help to find a job from the state.

Inequalities in demand for labour, present before the recession, have not been resolved. In 2013, labour market demand (measured by the gap between vacancies and unemployment) was weaker for people looking for elementary work or with no recent work history; and for people living in Ayrshire, Glasgow and the Clyde Valley, Tayside and the Forth Valley.

Household incomes have stopped falling but remain below their pre-recession peaks. Income in the poorest 30% of households began falling in 2004. Earnings, which fell sharply in 2009, remain depressed.

Around one in five working-age adults in Scotland were living in relative poverty after housing costs in 2013/14, a figure that has fluctuated without much change since the mid-1990s. Since 1996, the proportion of working-age adults in Scotland living in poverty has remained consistently higher than the proportion living in 'workless households', reflecting high levels of in-work poverty. In 2013/14, almost half of all people in Scotland affected by poverty (46%, 430,000) lived in a household where at least one adult was in employment.

Most households saw an improvement in their subjective financial position in the early 2000s, stability until 2007 and then deterioration during the recession.



Lone-parent, single-adult and large-family households were most likely to report that they were not managing well financially in 2014. Some groups (single adults and large families) saw their position continue to deteriorate after the official end of the recession.

The association between the threat and use of JSA sanctions and labour market outcomes in Scotland is unclear. Before the recession, large increases in the use of sanctions were associated with modest increases in exits from benefits to work. In periods of weak labour market demand, large increases in the use of sanctions were associated with falling exits from JSA to work, as fewer people left benefits for employment. In the recovery, improved labour market outcomes appear more closely aligned with changes to labour market demand than the stricter benefits regime.

## Health outcomes and health inequalities

- Mortality from coronary heart disease continued its long term-decline, though there is a suggestion that the rate of decrease has slowed in recent years.
- Working-age mortality from respiratory disease continues to decline.
- The proportion of working-age adults who were overweight/obese, which rose substantially between 1995 and 2008, appears to have levelled off for men and fallen slightly for women. However, for the lowest income quintile, the proportion of working-age adults who were overweight/obese started to increase again after 2010.
- Mental health problems for working-age adults declined between 1998 and 2003 but subsequently increased, with a particularly sharp increase in 2012/13. This trend was driven by deterioration in the mental health of working-age adults living in the lowest-income households.
- Mortality from probable suicide among working-age men, which rose in the 1990s, fell sharply in 2003 and has subsequently fluctuated without a clear trend. The long-term trend for women has been fairly flat.
- Alcohol-related mortality, which rose steeply (especially for men) in the 1990s, began to fall in the early 2000s. This was driven by steep falls for adults in the most deprived areas of Scotland.
- Drug-related deaths increased in the late 1990s, levelled off in the early 2000s, rose in the late 2000s and have fluctuated at a high level since 2007.
- Recorded violence, which increased in the 1990s, peaked between 2006 and 2008 and has been falling since then. Mortality from assault declined sharply after 2007 for men; for women there was a temporary increase (albeit from a low base) during the recession.
- Absolute inequalities in all-cause mortality among working-age adults declined between 2001 and 2012, whilst relative inequalities in all-cause mortality increased until 2008 before subsequently declining.

- Deaths from HIV/AIDS increased in the 1990s, stabilised in the early 2000s, and fell in 2012, before fluctuating without a clear trend.
- Mortality from road traffic accidents (RTAs) fell steeply for working-age men during the recessions of the 1980s, 1990s and 2000s. For women, trends in mortality from RTAs show a slow, steady long-term decline.

## Rapid review of the literature

Based on a rapid review of relevant literature published between 2010 and December 2014, it is likely that:

- the net changes to social security are highly regressive
- the impact of social security reforms will be distributed unequally across population groups with protected characteristics, such as people with disabilities
- some individuals and household types will be affected by multiple social security changes
- the capacity of individuals and households to respond to these changes will be constrained by circumstances
- lone parents, large families, households with at least one disabled member and young adults will be especially vulnerable to the changes announced to social security.

These groups were already facing financial strain even prior to the recession and the most recent round of social security reforms.

## Discussion

Recovery in output and employment in Scotland was underway by 2013/14. However, this had not yet fully translated into improvements in living standards for many by 2013 – and many of the underlying inequalities in income and employment opportunities, present before the recession began, still exist.

Social security reforms have intensified since the baseline report, and there are signs that this has led to some people exiting the benefits system without securing stable employment.

The combined health impacts of economic change and social security reforms appear to have been mixed:

- Recession was associated with falls in road accident deaths, a pause in the rise in obesity at population level and continued falls in alcohol-related mortality. However, it may also be associated with a temporary rise in female mortality from assaults (albeit from a low base).

- From 2010, there were signs of a slowing in improvement in some aspects of population health, widening inequalities in mental health due to a deterioration in the position of low-income working-age adults, and narrowing inequalities in overweight/obesity due to rising prevalence of overweight/obesity among the poorest.
- Although it may be premature to attribute these changes to social security reform, the association between poorer working-age mental health and the level of sanction activity applied to unemployed people claiming JSA is striking.

Overall, the evidence assembled here suggests a number of policy implications:

- In the short term, measures to mitigate any ill-effects of social security reforms through service provision should be maintained and strengthened.
- Consideration could be given to increasing the value of social security benefits, reducing conditionality and reduced use of sanctions in order to protect population health.
- In the medium term, consideration could be given to how the opportunities flowing from the Smith Commission related to social security powers can protect health.
- Efforts should be made to ensure income growth in the recovery does not damage health by:
  - measures to ensure economic growth is equitable, for example by increasing the quantity and improving the quality of employment opportunities available in Scotland
  - further regulation of food and alcohol markets.

There is a continued need for monitoring of the impact of economic change and social security changes on health and health inequalities. This could include further development and use of tools such as Triple-I and Health Inequalities Impact Assessments, as well as exploring data linkage. These approaches would also improve confidence in systematic reviews of the literature on these topics.

The next update to this report will take place in 2017.

# 1.0 Introduction

## Background

Income, along with education and employment, is a fundamental determinant of health inequalities.<sup>1</sup> The purpose of social security is to provide a degree of financial protection to those who cannot work due to age (such as children and pensioners) or circumstances (caring responsibilities, incapacity or disability), as well as those in work on low incomes or those who face additional costs (such as disability costs). Changes in income, whether due to changes in the economy and labour market or the social security system, therefore have the potential to impact on health and health inequalities.

This report updates *Making a Bad Situation Worse?*,<sup>2</sup> which provided a baseline perspective on the potential impact of recession and changes to social security on health and health inequalities in Scotland. *Making a Bad Situation Worse?* showed trends in the economy, labour market and health outcomes up to 2011, a period during which the Scottish economy had not yet started to recover from the effects of the recession, and before many of the features of the Welfare Reform Act 2012 came into force. An improving economy coupled with further changes to social economy might be expected to exert mixed effects, pulling in different directions, on household incomes and income inequality, and therefore on health. This report investigates the extent to which this is the case.

## Aims

The aims of this report are to:

- provide an update on developments in the social security system, and the changing economic context, for Scotland, using the latest published information
- monitor changes in population health and health inequalities for those outcomes with the most plausible associations with the state of the economy and the social security system
- review the literature published since 2010 to identify whether and which subgroups of the population have been disproportionately negatively affected by social security reform
- summarise the main findings and highlight implications and areas for future work.

## Structure

The report is structured as follows. The methods section highlights the main data sources used, why the health outcome indicators were chosen and the approach taken with the rapid review of literature. The results section presents relevant data on the social security changes (up to 2015), and the changing economic context, generally to 2013 (or 2014 where this is possible). It also provides analyses of trends in health outcomes, again usually up to 2013 (the latest year for which published data were available). A final section draws together the main findings (and limitations) of the report and discusses the implications for policy and further research.

## 2.0 Methods

### Analyses of routine data

The most recent available data on developments in the working-age social security system were obtained from the Department for Work and Pensions (DWP) (including the DWP Stat-Xplore site).

Information on the changing economic context was obtained from various sources, including the Scottish Government, DWP Households Below Average Income (HBAI) dataset, NOMIS (which provides detailed labour market statistics from the Office for National Statistics), the UK Commission for Employment and Skills, Annual Population Survey (and Labour Force Survey) and the Scottish Household Survey. Indicators are presented on:

- gross value added (GVA) and income inequality
- employment, unemployment and worklessness
- demand for labour
- income, earnings and poverty
- Jobseeker's Allowance (JSA) benefits sanctions.

Health and health inequalities data presented here follow the framework used in the baseline report. Indicators are presented on:

- cardiovascular disease and respiratory illness
- obesity
- mental health and wellbeing, suicide, alcohol and drug-related mortality
- excess winter mortality
- health inequalities
- violence
- Human Immunodeficiency Virus (HIV) and tuberculosis.

Time trends data for these indicators are presented, wherever possible, both for men and women as a whole, and for Scottish Index of Multiple Deprivation (SIMD)/equalised household income quintile.

Data were obtained from a range of sources, including Information Services Division, NHS National Services Scotland, National Records of Scotland, the Scottish Health Survey and Health Protection Scotland.

## Literature review

Section 3.4 presents the findings from a rapid evidence review which aimed to identify whether, and in what ways, different population subgroups in Scotland were affected by the social security reforms introduced (or consolidated) since the UK government election in May 2010. The review questions were:

- Were subgroups of the Scottish population disproportionately affected by the social security changes introduced, consolidated or proposed by the UK government in May 2010?
- In what ways have specific subgroups of the Scottish population been affected by different aspects of social security reform since 2010, and with what actual or potential effects on health and health inequalities?

The searches were undertaken to identify peer-reviewed and grey literature in a number of phases over the period September–December 2014, using relevant databases (Medline, Web of Science, UK Theses Titles, Google Advanced, Institutional Repository Search) and websites. These were cross-referred with the ongoing updates of welfare reform publications produced by Health Scotland's Knowledge Services team. In addition to the database searches, citations identified in the literature were followed up where these were felt to be relevant to the review question and met the inclusion criteria.

The literature was critically appraised using the AACODS (authority, accuracy, coverage, objectivity, date, significance) checklist, developed by Flinders University to appraise grey literature.<sup>3</sup> To be included in the review, material had to meet all of the following criteria:

- published between May 2010 and December 2014
- explicitly addressed one or more aspects of the social security changes introduced, consolidated or proposed by the UK government since 2010
- included a description or analysis of the social security changes on different subgroups of the population
- described the methods used or sources of data used.

To check the consistency of decisions on whether to include or not, two assessors independently assessed the first 22 citations against the inclusion criteria.

Agreement was reached in relation to 19 of these (86%). The remaining three were identified as borderline for inclusion by one reviewer.

Of 189 papers identified, 35 met the initial inclusion criteria. Only four of these were published in peer-reviewed journals, though this may partly reflect time lags in papers going through the submission and review process.

A data extraction template was developed to capture the findings from the work reviewed in terms of:

- the population subgroup identified
- the nature of the welfare change with implications for the identified subgroup, e.g. benefits capped/reduced/increased, benefit application process, conditionality/sanctions, delivery method, eligibility criteria, etc.

Appendices 1 and 2 provide details of the search strategies, websites consulted and search terms used. The data extraction template is included in Appendix 3.

Note that while this approach aimed to minimise the danger of bias, confounding, error and selective reporting in the selection of literature, the grey status of the literature and the decision to undertake a rapid, rather than full, review mean these findings should be considered indicative rather than definitive.



## 3.0 Results

### 3.1 Developments in the social security system

This section sets the context for the update report by summarising the most recent information on changes to the working-age social security system in Scotland.

#### The Work Programme

The Work Programme is the main DWP-funded programme designed to promote employability and support the long-term unemployed into sustainable work. Between its launch in June 2011 and March 2015, 167,900 people in Scotland were referred to the Work Programme. Of those who were eligible to do so, 38,511 (23.8%) achieved a job outcome,<sup>a</sup> below the average for Britain of 25.9%.<sup>4</sup> It is not clear how many of these outcomes would have occurred in the absence of the programme.

#### Universal Credit

Universal Credit (UC) is a new benefit designed to fold (almost) all existing working-age benefits and tax credits into one single benefit. Its aims are to simplify the benefits system for claimants and administrators, reduce the risk of fraud and error and provide clearer signals of the financial benefits of entering paid employment and increasing the number of hours worked. UC began to be piloted in Scotland in December 2013. By March 2015 there were 880 people in Scotland on the UC caseload, almost all of whom were resident in the North of Scotland Jobcentre District. Roll out of UC in the most populous parts of Scotland commenced in March 2015.<sup>5</sup>

#### Personal Independence Payment (PIP)

Personal Independence Payment (PIP) started to replace Disability Living Allowance (DLA) for people aged 16 to 64 years from 8 April 2013. Between this date and 30 April 2015, in Scotland:

- 83,900 new claims for PIP had been registered and 74,050 had been cleared (i.e. either a decision to award or disallow the claim had been made, or the claim had been withdrawn by the claimant)
- 12,950 DLA reassessments had been registered for PIP and 8,650 had been cleared.

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<sup>a</sup> A job outcome is a continuous or cumulative period off benefits and in paid employment within a 12-month period. The period of time in work required to count as a job outcome varies from 13 to 26 weeks, depending on the benefit previously claimed by the person achieving the job outcome.

Excluding withdrawn claims, 52% of new claims for PIP for people in Scotland were successful, rising to 99% under the special rules for the terminally ill.<sup>6</sup> We are unable to say how these compare to new claims for DLA, as no comparable figures are available.

In April 2015, the average time taken (across the whole of Britain) between someone registering for PIP and a final decision by the DWP was 11 weeks for new claims and 10 weeks for reassessments. The time taken to process claims has improved over time, from a peak of 41 weeks for new claims and 32 weeks for DLA reassessments).<sup>5</sup>

## Conditionality and sanctions for the unemployed

In October 2012, the DWP introduced a tougher sanctions regime for working-age JSA claimants. From that point, people claiming JSA, the main benefit for unemployed people, faced a minimum loss of four weeks' benefit if they missed an appointment with their advisor without good reason or failed to participate in the Work Programme without good reason. They faced disentitlement of benefits and up to four weeks' loss of benefit if they were judged to be 'not actively seeking employment'. The severity and duration of penalties associated with sanctions can also escalate quickly, with the maximum sanction being loss of benefit for three years.<sup>7</sup>

Between October 2012 and March 2015, 163,470 JSA sanctions were applied to 90,990 individuals in Scotland. Almost half of referrals to a decision-maker, where doubt has been raised over a benefit claim, made since October 2012 have resulted in sanctions being applied. In 2014/15, the average rate of sanctions in Scotland was 4.1 per 100 JSA claimants a month. This compares with a lower rate of 2.6 per 100 per month observed for the period 2000/01–2005/06,<sup>b</sup> when a less severe system of penalties associated with sanctions applied.<sup>8,9</sup> Section 3.2 explores trends in sanctions and labour market outcomes in Scotland in more detail.

## Conditionality and sanctions for those with long-term health conditions

Employment and Support Allowance (ESA), is the main benefit for working-age people who are unable to work due to long-term serious illness or disability. In order to qualify for ESA, claimants must undergo a Work Capability Assessment (WCA). After this process they are either:

- found eligible for ESA but in the 'work-related activity group' (WRAG) (with greater conditionality around preparation for work and a lower rate of benefits)
- placed in the support group (sufficiently impaired to prevent them making any steps towards moving into work); or

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<sup>b</sup> The claimant count was adjusted to take account of the different treatment of those participating in government training schemes before June 2011.

- found fit for work (and therefore not eligible for ESA).<sup>10</sup>

Between October 2010 and September 2014, 151,750 working-age people in Scotland claiming benefits owing to incapacity to work had been reassessed under the Work Capability Assessments. Of these, 41% were placed in the WRAG, 43% in the support group and 16% found 'fit to work'.<sup>11</sup>

From December 2012, ESA claimants in the WRAG were also subject to a new, stricter sanctions regime. Between December 2012 and March 2015, 4,989 sanctions were applied to 3,279 individuals in Scotland.<sup>12</sup>

## The Smith Commission

In November 2014, the Smith Commission, which had been appointed to review further devolution of powers to the Scottish Parliament in the light of the Scottish referendum on independence, published its recommendations.<sup>13</sup> Those most relevant to working-age social security benefits include:

- Administration of almost all aspects of UC (including conditionality and sanctions) will remain reserved to Westminster. However, the Scottish Government will be given the power to change the frequency of payments, pay landlords direct for housing costs, vary the housing costs elements of UC and vary the plans for single household payments.
- The devolution of powers over some other benefits to the Scottish Parliament:
  - Benefits for carers, disabled people and those who are ill: Attendance Allowance, Carer's Allowance, DLA, PIP, Industrial Injuries Disablement Allowance and Severe Disablement Allowance.
  - Benefits which currently comprise the Regulated Social Fund: Cold Weather Payment, Funeral Payment, Sure Start Maternity Grant and Winter Fuel Payment.
  - Discretionary Housing Payments.
- Giving new powers to the Scottish Parliament to create new benefits in areas of devolved responsibility and to make discretionary payments in any area of social security without the need to obtain prior permission from DWP.

Smith also recommended administration of Jobcentre Plus remain reserved but responsibility for delivery of employment programmes (largely the Work Programme) be devolved to the Scottish Parliament once the current contracts with providers have expired. The UK Government published its response in January 2015, outlining draft clauses which would put into effect many (though not all) of the Smith recommendations.<sup>14</sup> The Scotland Bill 2015–16, which would make these clauses legally binding, was presented to the House of Commons in May 2015 and had reached its second reading in the House of Lords by November 2015.

## Announcements in the July 2015 Budget

The 2015 UK summer budget introduced a number of further changes to the employment and social security system which will also apply to Scotland. These included:

- an increase in the level of the national minimum wage (for adults aged 25 and over) to £7.20 an hour in April 2016
- increasing the tax-free personal allowance to £11,000 in April 2016/17
- the freezing of working-tax credits for four years from 2016/17
- limiting support from child tax credits to two children to children born from April 2017
- reducing the amount paid to new ESA claimants in the WRAG to the same level as JSA.<sup>15</sup>

Independent commentators have suggested that these changes, including the increase to the national minimum wage, are likely to have a mixed impact. Some groups (e.g. lone parents, working-age adults not in employment) are likely to see their financial position worsen over time, and others (low-income working-age adults without children or with no childcare costs) are likely to see a substantial improvement.<sup>16</sup>

## Summary

Since the publication of the baseline report, changes to the social security system have continued. For claimants with health problems and disabilities, PIPs have begun to replace DLA and increased conditionality was introduced for those claiming ESA. Since June 2011, the Work Programme has assisted more than 38,000 people in Scotland into employment, though more than 94,000 people claiming JSA or ESA have also been sanctioned since October/December 2012 under the tougher benefits regime. The Smith Commission has also made a number of recommendations for devolution of some aspects of social security to the Scottish Parliament, many (but not all) of which are included in the Scotland Bill 2015–16. Policies announced in the July 2015 budget are likely to produce mixed results, with some groups (e.g. lone parents, working-age adults not in employment) likely to lose out.

## 3.2 Income and employment outcomes

As discussed in the baseline report, the theory of change describes key pathways through which it is expected the changes in the economic context and social security policy will impact on health outcomes and health inequality. There are several pathways for which data are readily available:

- changes to employment and unemployment
- changes to income and poverty levels
- changes to income inequality levels.

This section of the report describes time trends and, where data are available, inequalities for relevant indicators within the broader economic context.

### The changing economic context

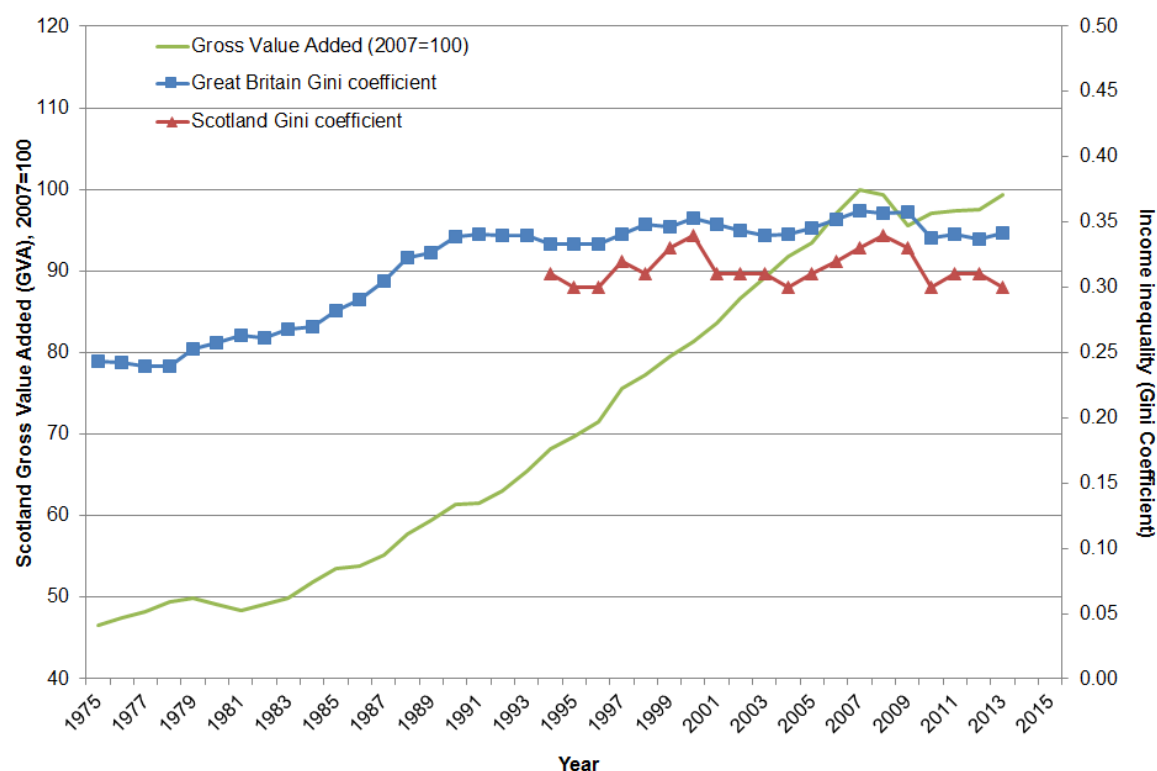
The UK recession officially began in the spring of 2008 and ended in the summer of 2009, but recovery in output and the labour market took far longer.<sup>17</sup> **Figure 1** updates trends in economic growth from 1975 in Scotland (as measured by Gross Value Added or GVA) alongside trends in income inequalities for both Scotland and Great Britain. It shows that economic activity had almost recovered to pre-recession levels by 2013, with output returning towards levels seen in 2007.

Between the mid-1970s and early 1990s, income inequality in Britain increased rapidly, with the Gini coefficient<sup>c</sup> rising from around the European median to among the highest in Europe. Income inequality in Scotland has been slightly below the British average since the mid-1990s (largely explained by higher levels of inequality in London and the South East). After 2009, income inequality fell in both Scotland and Britain as incomes from the most affluent dropped more quickly than for the poorest groups. Levels of income inequality have remained broadly stable since then. The Institute for Fiscal Studies has argued that the falls in inequality are likely to be temporary, as earnings begin to rise (benefitting those at the middle and top of the income distribution) and cuts to benefits for working-age people continue to be implemented.<sup>18</sup>

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<sup>c</sup> The Gini coefficient is a measure of the income dispersion within a population. A Gini coefficient of 1 would represent complete inequality, with one household having all the income and others having none; a Gini coefficient of 0 would represent complete equality, with all households having the same income.

**Figure 1:** Trends in economic output and income inequality, Scotland and Great Britain: 1975–2013



Sources: Scottish Government; Institute for Fiscal Studies; DWP Family Resources Survey, Households Below Average Income datasets

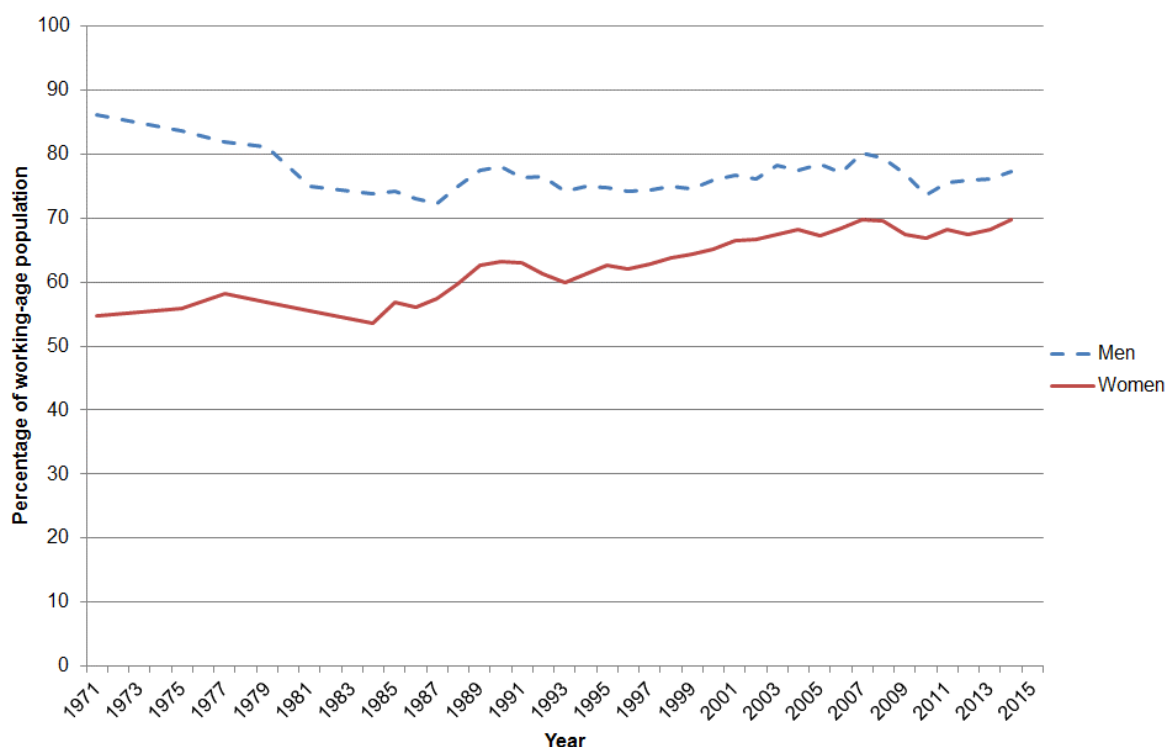
## Employment and unemployment

### Trends in employment

**Figure 2** shows long-term trends in employment rates for men and women in Scotland. Employment rates for men declined from the early 1970s to the late 1980s. They then began to increase, though it was only in 2007 that they exceeded 80%. Employment rates for women increased until the late 1970s then declined until 1984, before increasing steadily.

For both genders, employment rates declined sharply during the recessions of the early 1980s, early 1990s and late 2000s. Employment rates have been increasing for men since 2011 and for women since 2012. By 2014, female employment rates had returned to the levels seen before the 2008/09 recession, though male employment rates had yet to fully recover.

**Figure 2:** Trends in the working-age population (aged 16–59/64) in employment, Scotland: 1971 to 2014



Sources: Labour Force Survey; Census of Population; National Records for Scotland.

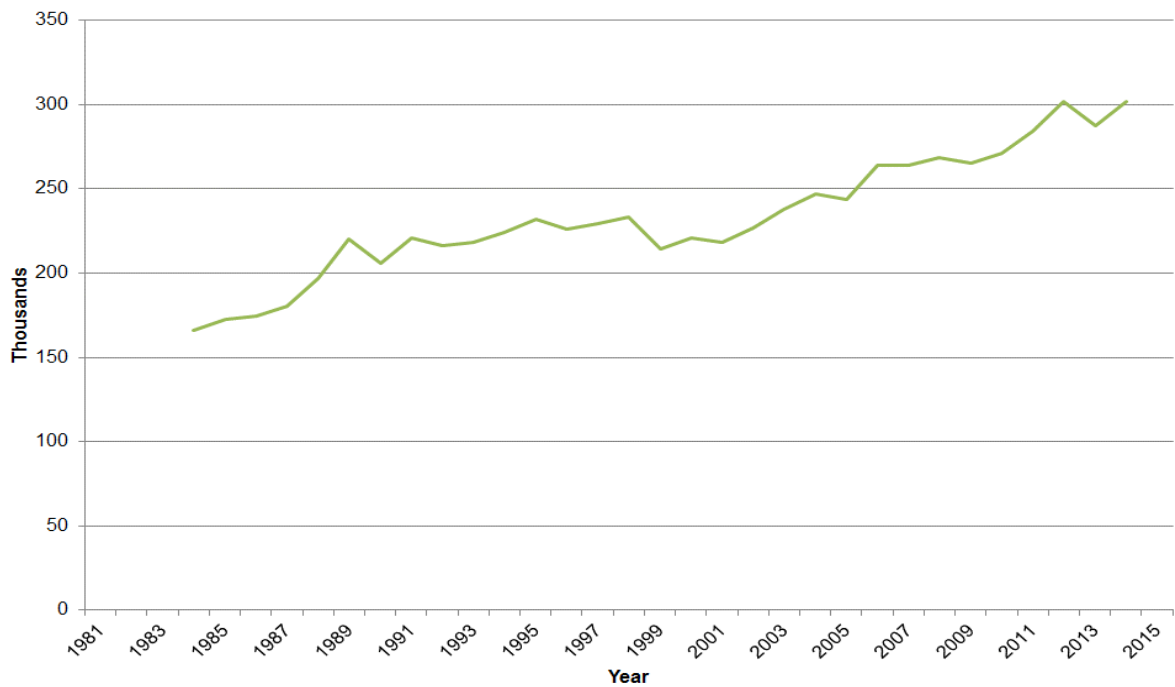
Within these headline changes, the characteristics of work have also changed over time. **Figure 3** shows the number of people in Scotland working part-time (because they could not find a full-time job) or in temporary work (because they could not find a permanent job) between 1984 and 2013. Both measures have historically increased during recessions and declined during periods of economic growth. There were 112,000 people working part-time but wanting full-time work in Scotland in 2014, an increase of more than 50,000 since 2007. Levels of involuntary temporary employment are higher than pre-recession levels, but are below their peak level in the mid-1990s. These trends are important because of the higher risk of poverty in working households where no-one has a full-time job.<sup>19</sup>

Self-employment trends in Scotland between 1984 and 2014 are shown in **Figure 4**. Levels of self-employment increased during the 1980s, were stable during the 1990s, then rose again between 2001 and 2006. They then remained flat between 2006 and 2010 before increasing again between 2010 and 2012. The number of adults in Scotland who were self-employed was at a historically high level in 2014. Self-employment is associated with increased mental wellbeing (for some).<sup>20</sup> However, this must be offset against the increased risk of poverty,<sup>19</sup> especially as earnings for the self-employed have fallen more sharply than for employees since 2006,<sup>21,22</sup> with commentators suggesting that ‘much new self-employment is low paid/low productivity’.<sup>23</sup>

**Figure 3:** Trends in the number of people working part-time or in temporary employment, not by choice (000s), Scotland: 1984 to 2014



**Figure 4:** Trend in the number of people in self-employment (000s), Scotland: 1984 to 2014



Sources: Labour Force Survey; Annual Population Survey.



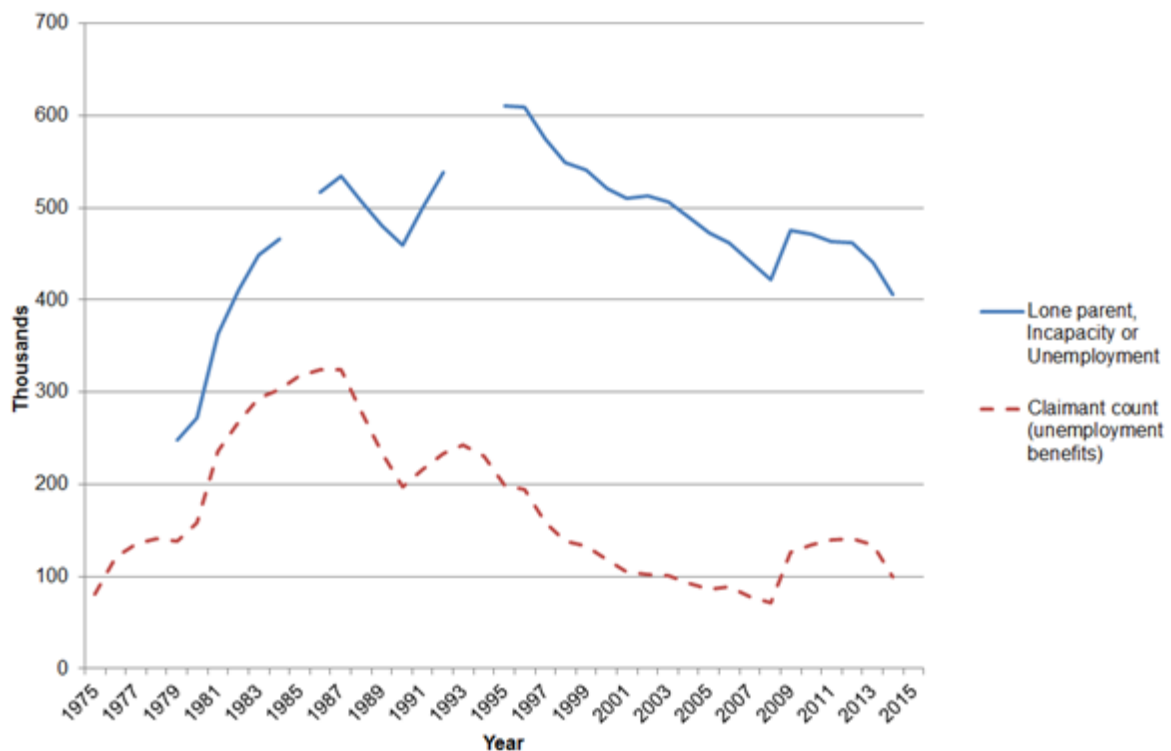
## Trends in worklessness

The situation for working-age adults not in employment also changed over time.

**Figure 5** compares the absolute number of people in Scotland claiming unemployment benefits ('the claimant count') with those claiming a broader range of 'out-of-work' benefits (unemployment benefits, lone parents' income support<sup>d</sup> or Incapacity Benefits).<sup>e</sup>

While both measures have broadly tracked the economic situation – rising in recessions and falling in recoveries – the proportion of working-age people on benefits claiming unemployment benefits declined over time. This was mainly driven by the diversion of people from unemployment benefits to incapacity benefits.

**Figure 5:** Trends in the number of people claiming key out-of-work benefits (000s), Scotland: 1975 to 2014



Sources: Hansard; DWP 100% WPLS; DWP 5% sample. Data on lone parents in Scotland claiming supplementary benefit n/a for 1985 and 1994, data on Invalidity Benefits n/a for 1993 and 1994 – results have been omitted for these years.

<sup>d</sup> Some lone parents claiming Income Support were also in employment.

<sup>e</sup> 'Incapacity Benefits' defined as Invalidity Benefit to 1994, Incapacity Benefit from 1995 and Employment and Support Allowance from 2008. 'Lone parents' include lone parents claiming supplementary benefit 1979–1987 or income support 1988–2014. Unemployment benefit was replaced by JSA in 1996.

Using the broader measure of those claiming out-of-work benefits, worklessness in Scotland increased from around 248,000 in 1979 to 539,000 in 1987. It then fell to 468,000 in 1990, before increasing to more than 600,000 in the early- to mid-1990s. This total declined steadily until around 2008 before rising again. The number of people claiming out-of-work benefits fell steeply from 2012, mainly driven by the fall in JSA claims. By 2014, the level of people claiming out-of-work benefits was at pre-recession levels, though this was still high by historic standards.

As discussed elsewhere,<sup>24</sup> there are emerging concerns around the widening gap between those claiming unemployment benefits and those defined as unemployed [according to the official survey-based measure set out by the International Labour Organisation (ILO)], but not claiming benefits. **Figure 6a** shows the absolute number of working-age people included in the claimant count measure against those counted by the ILO measure.

**Figure 6a:** Number of claimant unemployed and ILO unemployed (000s), Scotland: 1984–2014



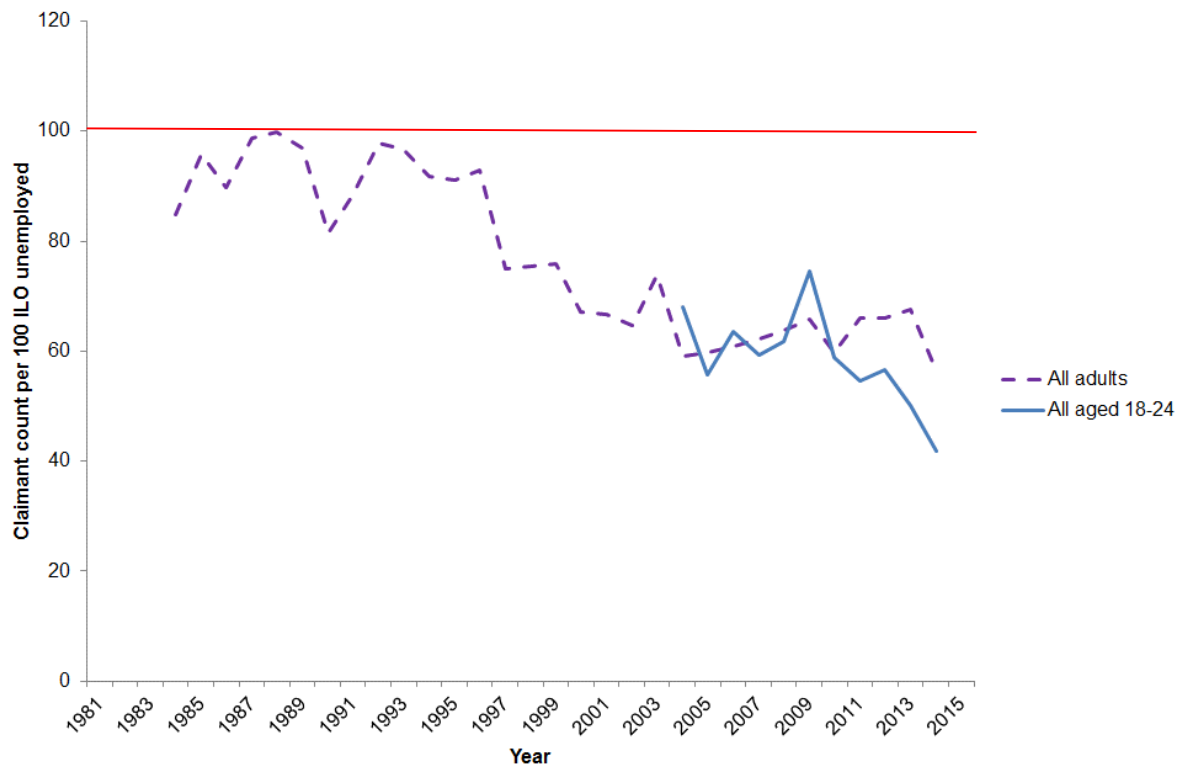
Sources: Labour Force Survey; Claimant count

**Figure 6b** illustrates that prior to the introduction of JSA in 1996, the association between the two measures was close, with around 90–100 people claiming unemployment benefits for every 100 people meeting the criteria for ILO unemployment. This fell steadily afterwards to a rate of 62 per 100 in 2007.<sup>f</sup> While it

<sup>f</sup> From DWP data on benefits take-up, it is likely that this change disproportionately affected single males without children.

rose temporarily during the recession, the rate fell again to 56 per 100 in 2014. For young adults (aged 18–24), the rate of claimant count unemployed to ILO unemployed stood at 59 per 100 in 2007: by 2014, this had fallen to 42 per 100. This suggests that recent policy changes (including increased conditionality) may also result in decreased levels of benefit take-up by those in need, especially young adults.

**Figure 6b:** Rate of claimant unemployed per 100 survey-based unemployed, Scotland: 1984–2014



Sources: Annual Population Survey; Labour Force Survey; Claimant count. Young adult figures include UC claimants not in employment.

## Inequalities in the demand for labour

Securing and maintaining employment can play an important role in protecting families and individuals against poverty and poor health. For this to happen, demand for labour has to be sufficient to absorb the unemployed who are seeking work. In this section, inequalities in the demand for labour are examined using two sources of data:

- Unemployment is measured by the number of adults aged  $\geq 16$  years available for and currently seeking work, defined according to the ILO survey-based measure.
- Demand from employers is measured by the level of vacancies reported in the 2013 Employers Skills Survey for Scotland.

The rate of unemployed people per 100 vacancies gives an indication of the effective demand for labour.

**Figure 7a** compares the number of unemployed people in Scotland by their previous occupation with the number of vacancies by occupation in 2013. For professionals, the number of vacancies exceeded the number of unemployed people with previous experience in these types of job. However, the number of unemployed people exceeded the number of vacancies for all other occupations. **Figure 7b** shows the rate of unemployed people per 100 vacancies. This was highest for elementary occupations (603 per 100 occupations) and skilled trades (409 per 100 vacancies). For those with unclassified/no previous occupation it was even higher (4414 per 100 vacancies) (data not shown).

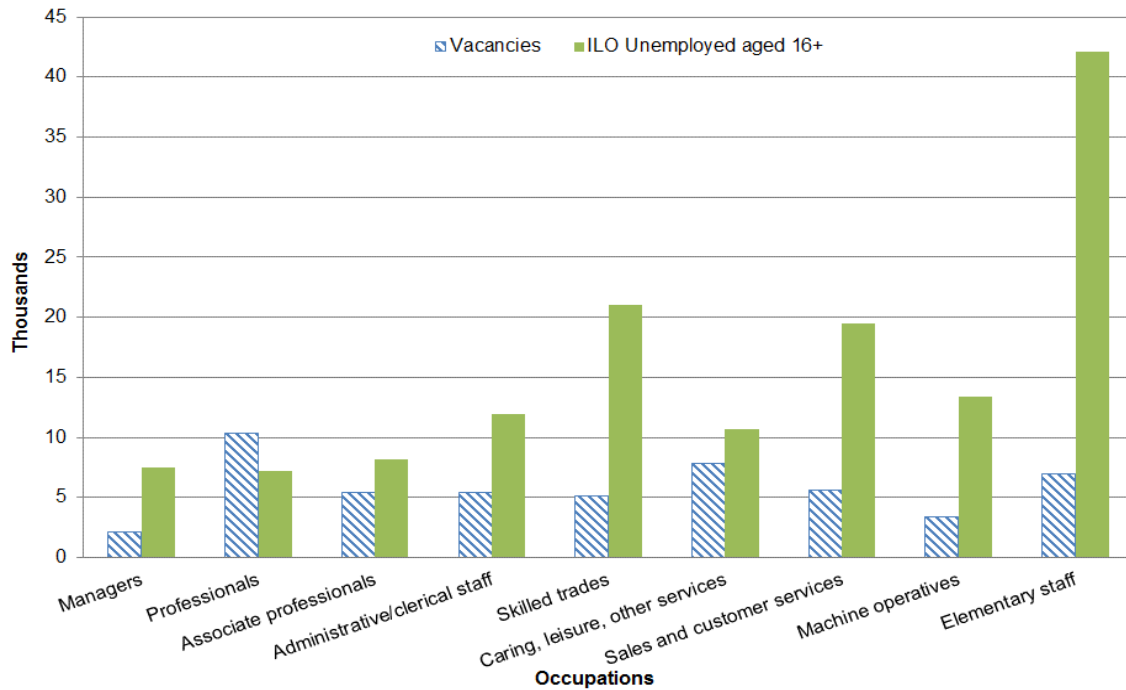
The geographical spread of vacancies and unemployment across Scotland in 2013 is illustrated in **Figure 7c**. Only one region of Scotland, Aberdeen City and Shire, had more vacancies available than unemployed people seeking work – in every other region, unemployment levels exceeded the number of available vacancies.<sup>9</sup> The rate of unemployed people per 100 vacancies for regions is shown in **Figure 7d**. This was highest in Ayrshire (753 unemployed people per 100 vacancies), Forth Valley (498 per 100), Tayside (487 per 100) and Glasgow and the Clyde Valley (483 per 100).

This analysis suggests that spatial and occupational inequalities in labour market demand persist in Scotland, and in 2013 demand was weakest for people seeking elementary occupations or with no recent work history, or living in older industrial parts of Scotland. These issues were present before the recession, but appear to have been amplified in the economic downturn.<sup>25</sup> Given that the opportunity to work is not equal, this limits the extent to which unemployed people (especially those claiming out-of-work benefits) can readily secure employment.

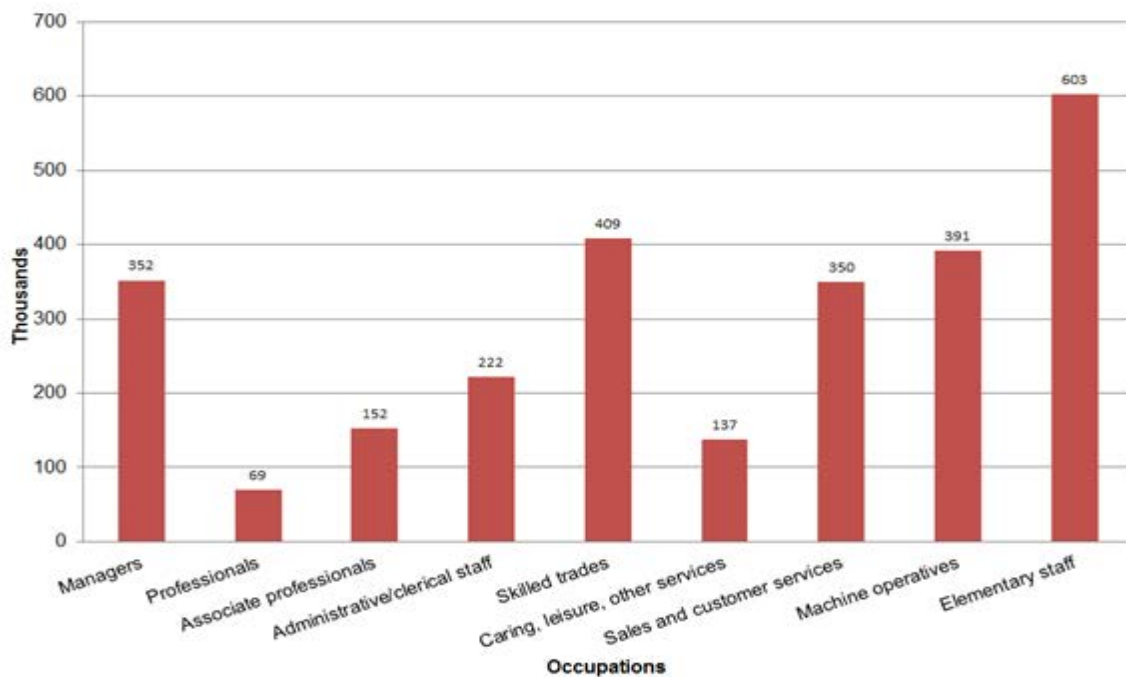
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<sup>9</sup> This data reflects the situation prior to the most recent downturn in the North Sea oil and gas industry, though it is unclear whether the labour market impact of redundancies will disproportionately affect the Aberdeen City and Shire economy or be more widely dispersed across Scotland.

**Figure 7a:** ILO unemployed and vacancies (000s) by standard occupational classification (SOC): Scotland, 2013

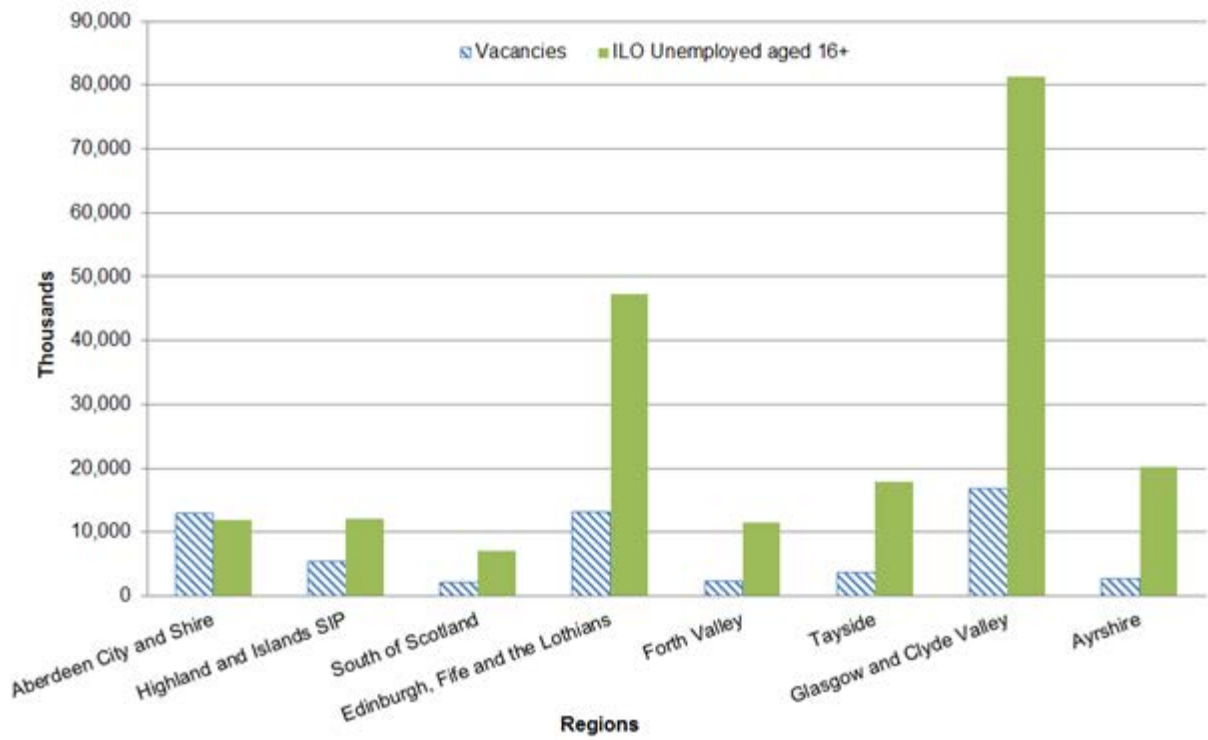


**Figure 7b:** ILO unemployed per 100 vacancies, by standard occupational classification (SOC): Scotland, 2013

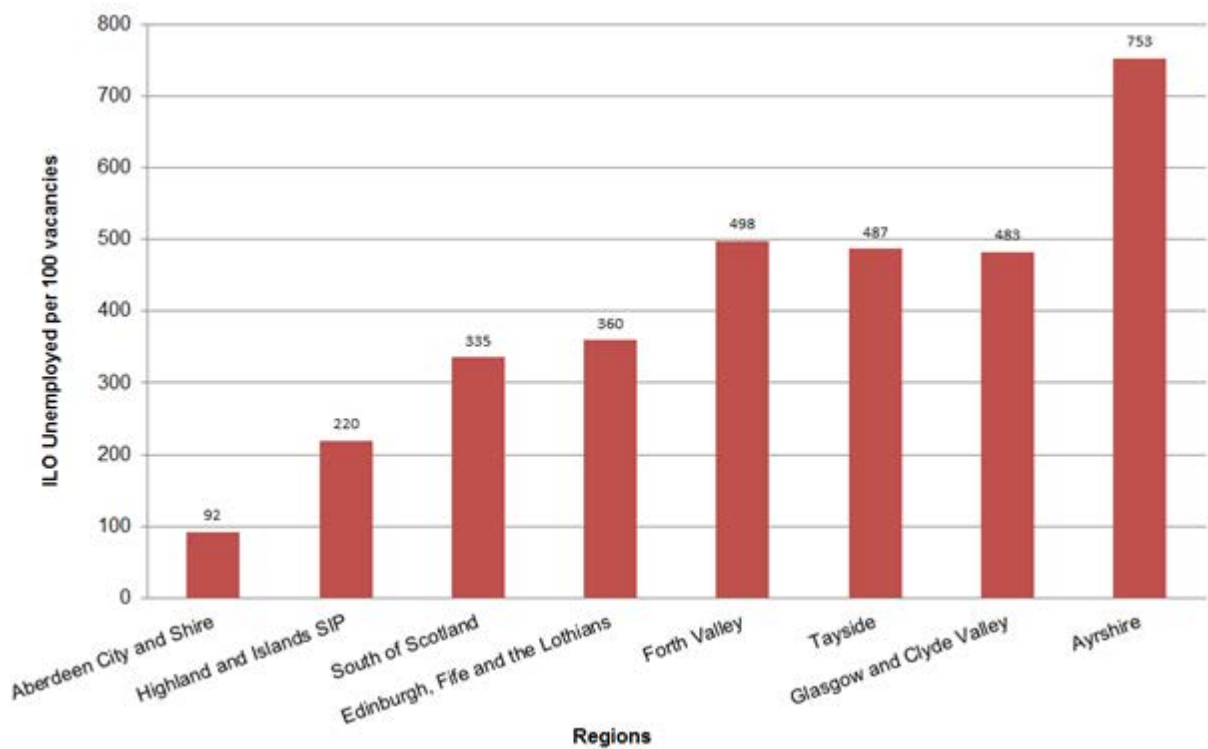


Source: UK Commission's Employer Skills Survey (UKCESS) 2013: Scotland results and Scottish RSA results; Annual Population Survey.

**Figure 7c:** ILO unemployed and vacancies (000s), by region: Scotland, 2013



**Figure 7d:** ILO unemployed per 100 vacancies, by region: Scotland, 2013

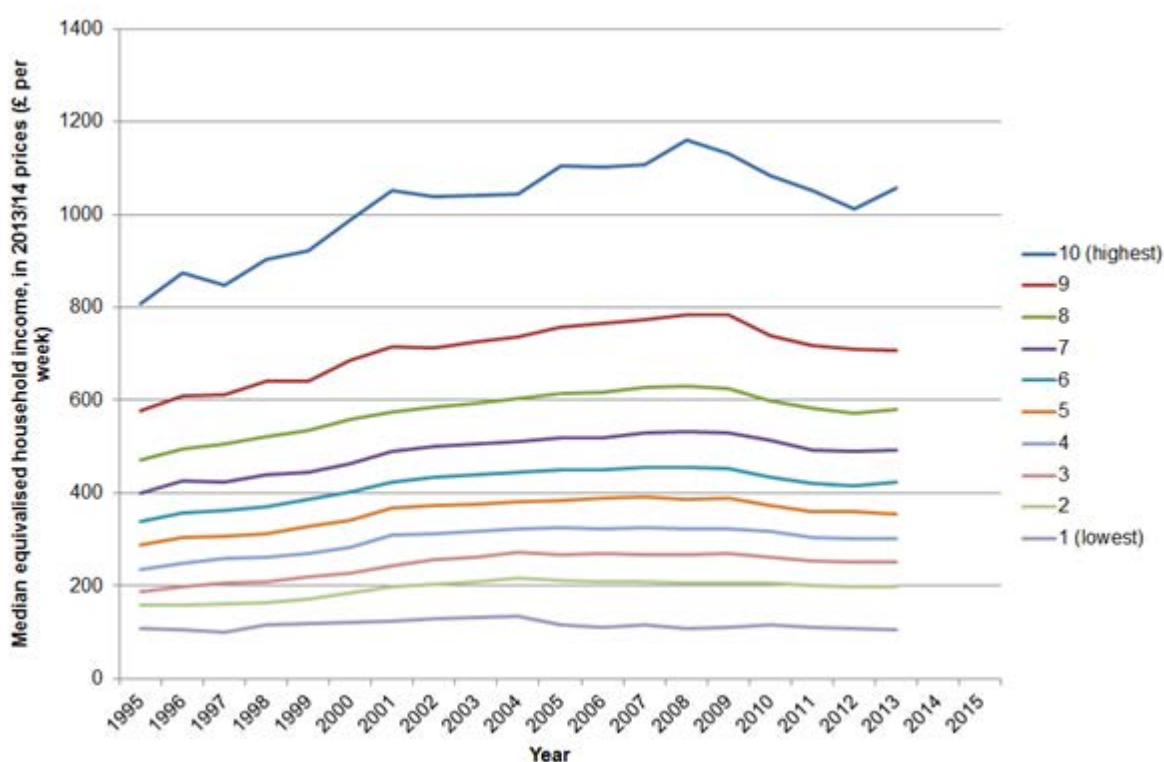


Source: UK Commission's Employer Skills Survey (UKCESS) 2013: Scotland results and Scottish RSA results; Annual Population Survey.

## Income, earnings and poverty

**Figure 8** shows the distribution of household incomes (after housing costs and in constant 2013/14 prices, adjusting for inflation), by income decile, in Scotland since 1995. Household incomes for the poorest three deciles (measured after housing costs were taken into account) peaked in 2004 and then started to decline before the recession began. For the next three deciles, household incomes began to decline from 2008 and, for the top 40% of households, from 2009. Incomes for most deciles remained largely unchanged in 2013, apart from the highest income decile, who saw their median incomes after housing costs increase.

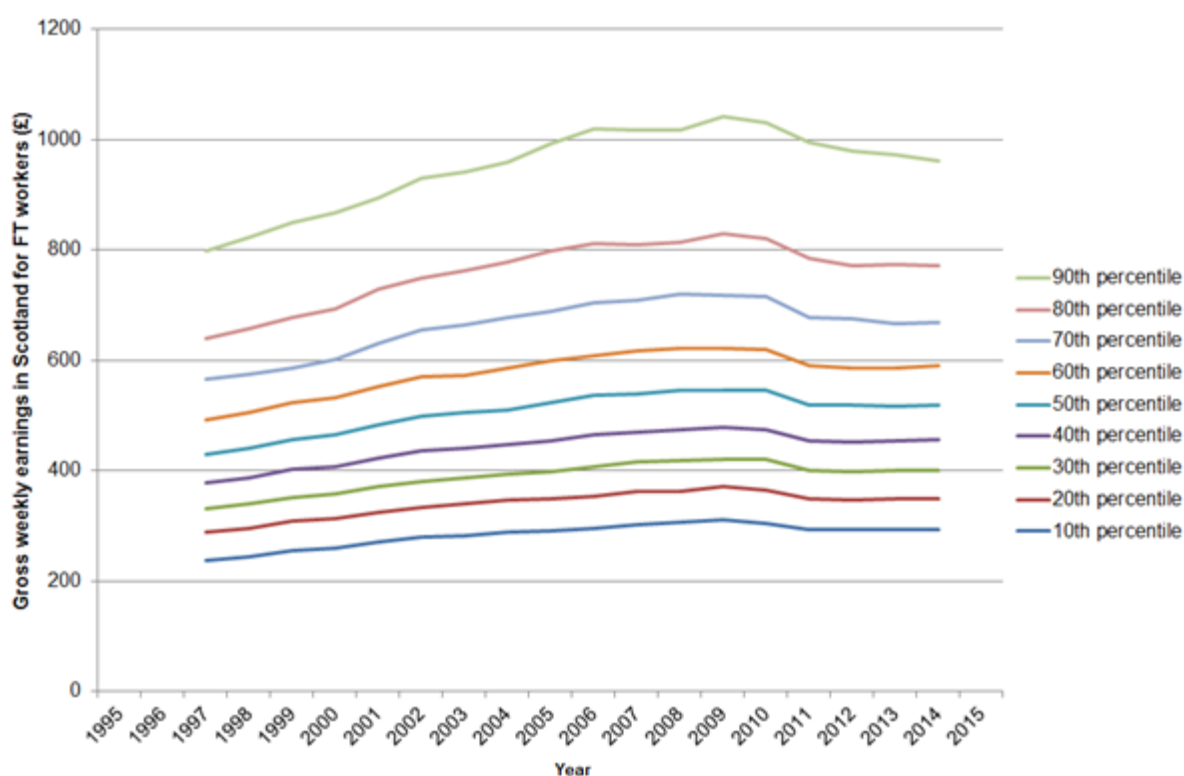
**Figure 8:** Income trends by income decile after housing costs and adjustment for inflation, (constant 2013/14 prices, £ per week), Scotland: 1995–2013



Source: HBAI dataset, DWP

Trends in real gross weekly earnings (for full-time workers, in 2014 prices) in Scotland show the effects of the recession. Real earnings growth came to a halt in 2009–10 and fell until 2012. Real earnings then stopped declining but remained below pre-recession levels (**Figure 9**).

**Figure 9:** Trends in real gross earnings (2014 prices) by percentile, Scotland: 1997–2014



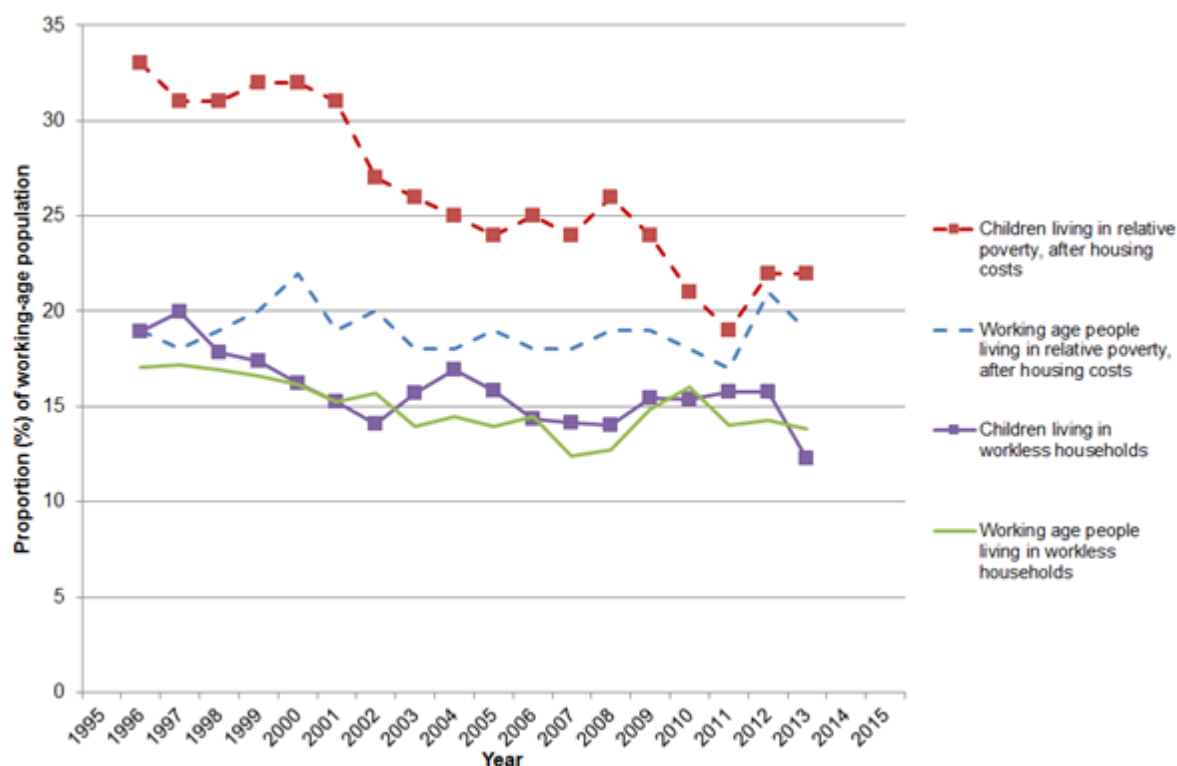
Source: Annual Survey of Hours and Earnings: Workplace Analysis, Full-time workers, Gross weekly pay

After housing costs, 19% of working-age adults in Scotland (approximately 600,000 people) were living in relative poverty in 2013/14. Half of them were living in households where at least one adult was in paid employment. The limitations of promoting work in isolation as a poverty-reduction strategy are also shown in **Figure 10**. Since 1996, the proportion of working-age people living in poverty has remained consistently higher than the proportion living in workless households, implying high levels of in-work poverty.

Between 1996 and 2013, the proportion of working-age adults in Scotland living in workless households fell from 17% to less than 14%. Only in the early 2000s did working-age poverty and worklessness decline together. In other periods, falling worklessness has been accompanied by rising or unchanged levels of working-age poverty. For children, the proportion living in poverty in Scotland has remained consistently higher than the proportion living in workless households since 1996, highlighting the persistence of in-work poverty. In 2013/14, almost half of all people in Scotland affected by poverty (46%) lived in a working household: an estimated 430,000 individuals.



**Figure 10:** Proportion of children and working-age adults (a) living in households where income < 60% median income (relative poverty) after housing costs and (b) living in workless households, Scotland: 1996/97 to 2013/14

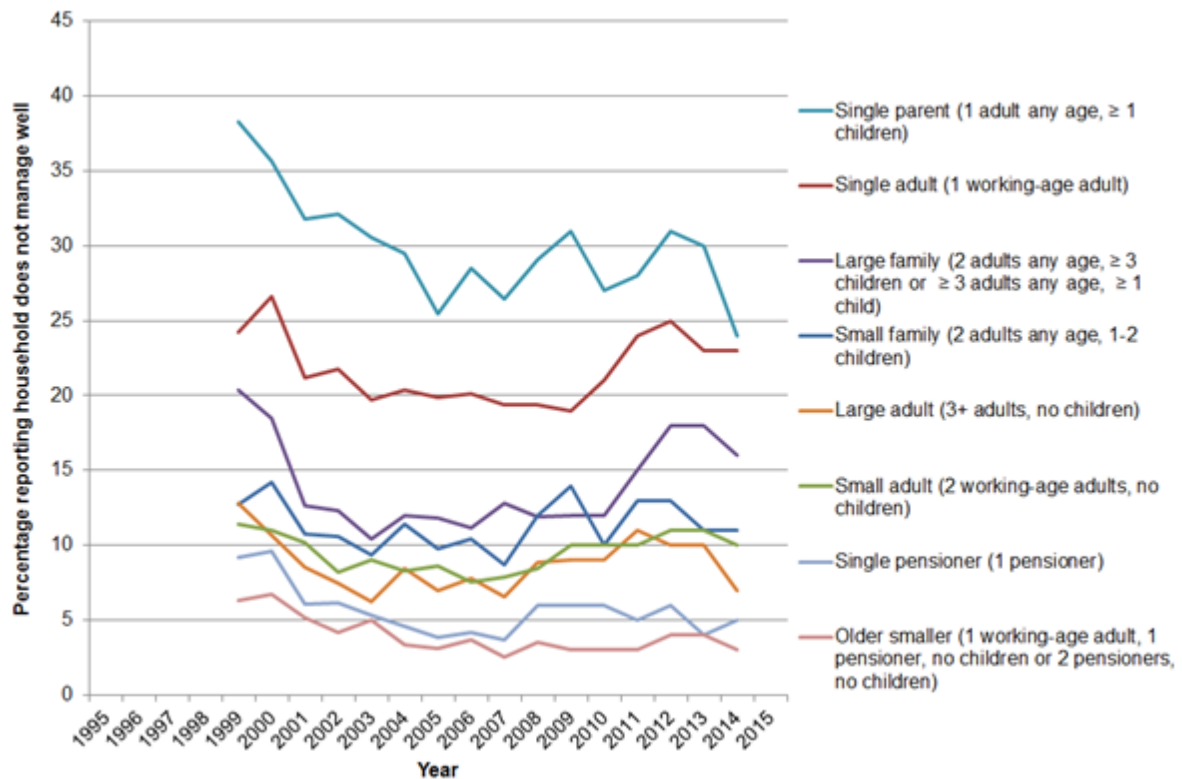


Source: HBAI dataset, DWP; Labour Force Survey household datasets.

Another way to examine trends in household incomes is to use more subjective measures, in this case the percentage of households reporting they were not managing well financially (**Figure 11**). Over the fifteen years between 1999 and 2014, single-parent, single-adult and large-family households were most likely to report they did not manage well financially.<sup>h</sup> The financial position of most households (except single pensioners) deteriorated from the late 2000s. For most household types, much of the increased concern about household finances occurred during the recession, but for some household types (single-adult and large-families) most of the change occurred after the end of the recession in 2009. Since 2011/12, the perceived financial position of most households has improved, but levels of financial difficulty are still higher than before the recession for almost all working-age households, except for lone parents.

<sup>h</sup> Including those reporting they were not managing well financially, had some financial difficulties or were in deep financial trouble.

**Figure 11:** Trends in the percentage of households reporting they ‘do not manage well financially’, Scotland, by household type: 1999 to 2014



Source: Scottish Household Survey.

## Jobseeker’s Allowance (JSA) Sanctions in Scotland

There is considerable policy interest in the use of benefit sanctions. Sanctions are penalties applied to working-age benefit claimants if they are judged not to meet the conditions associated with benefit receipt. Their stated aim is to encourage unemployed JSA claimants to search harder for employment, which in turn is expected to encourage greater exits from benefits into sustainable employment. From a public health perspective, the key questions are the extent to which sanctions achieve this aim and whether there are unintended consequences. If increased use of sanctions results in more people finding and keeping work, then this could be good for health (given the benefits associated with sustained work). If not, then sanctions will worsen the economic situation of low-income households and increase the uncertainty they face, with increased risk of negative impacts on their mental health. This would be consistent with earlier evidence from the DWP, which found that a lack of support and encouragement or a financial crisis were associated with a decline in mental health among JSA claimants.<sup>26</sup>

This section describes the association between JSA benefit sanctions and labour market outcomes for working-age Scottish adults between 2000 and 2014. Four relevant measures are used:

- The referral rate for sanctions (the ‘threat rate’) per 100 JSA claimants.

- The adverse decision rate (where sanctions are actually imposed) per 100 JSA claimants.
- The estimate rate at which people exit JSA for employment (exits to work) per 100 JSA claimants.
- The ILO unemployment rate.

Exits to work were estimated by taking the proportion of JSA claimants leaving the claimant count with a known destination<sup>i</sup> who were recorded as having moved into employment. This proportion was applied to the total number of people exiting the claimant count. The crude number was then expressed as a rate per 100 JSA claimants per month. This approach assumes that those without a recorded destination were as likely as those with a recorded destination to move into work.

**Figure 12** illustrates how the four measures changed over time, using annualised averages from October–September for each year. Changes in the measures can be divided into six periods:

- 2000/01 to 2005/06: the referral rate for JSA sanctions was declining and the adverse decision rate was stable. Exits into employment declined, but so did unemployment rates.
- 2005/06 to 2007/08: the referral rates for JSA sanctions and the adverse decision rate both increased. Exits into employment increased, while unemployment rates continued to decline.
- 2007/08 to 2008/09: demand for labour fell off sharply as the economy moved into recession. Both the threat and use of sanctions decreased. Exits from JSA to work decreased and unemployment increased sharply.
- 2008/09 to 2011/12: demand for labour stagnated at a very low level. During this period, threat and use of sanctions increased steadily back to levels seen in 2007/08. Exits to employment from JSA declined to a very low level, and unemployment rose steeply to plateau at more than 8%.
- 2011/12 to 2012/13: there was a dramatic increase in the referrals for and use of JSA sanctions. This coincided with the tougher regime of penalties associated with conditions for claiming JSA (introduced in October 2012) but also with a loosening of fiscal policy and substantial use of quantitative easing.<sup>27</sup> This was accompanied by a modest increase in exits from JSA to work but a steep fall in unemployment.

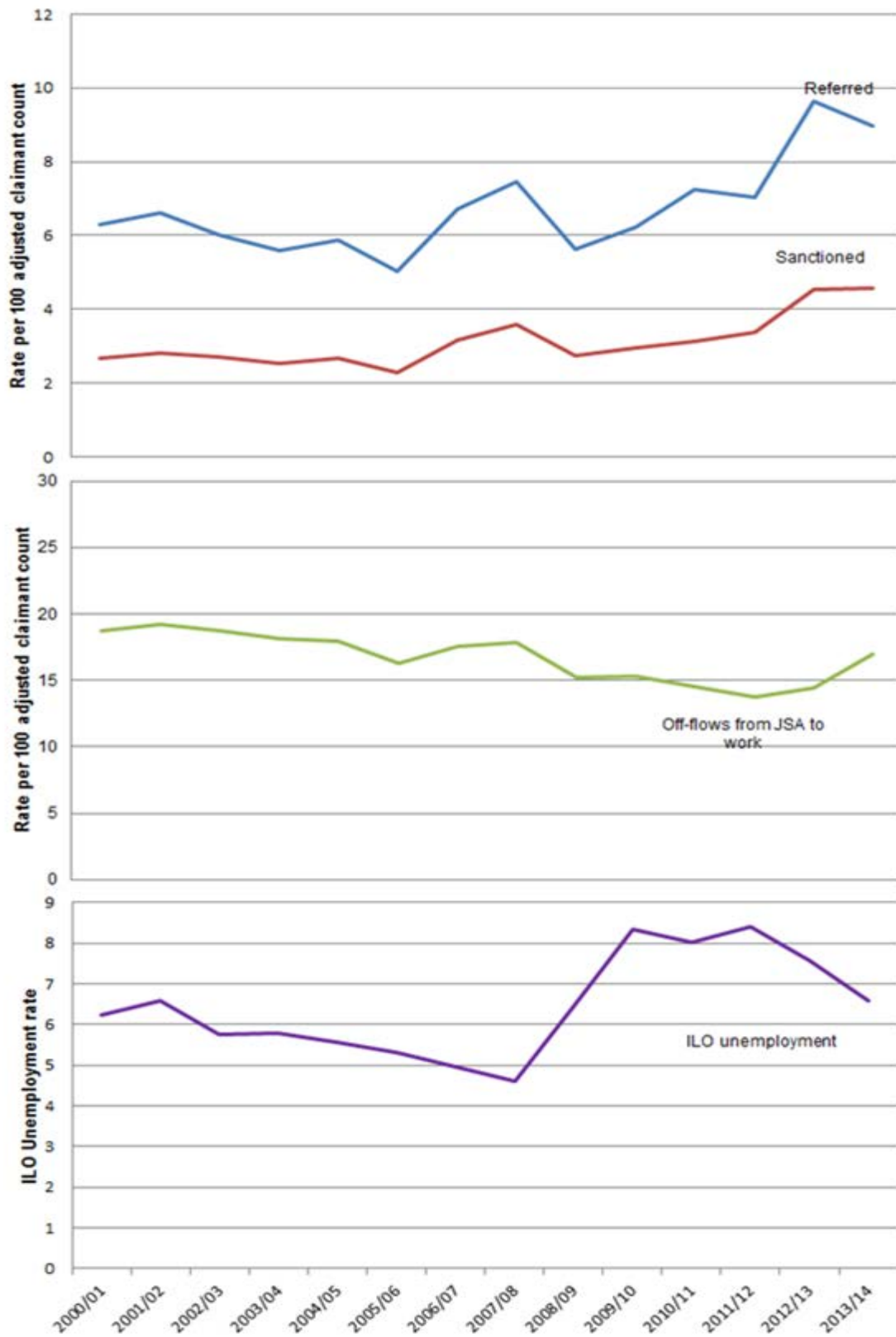
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<sup>i</sup> Excluding those who failed to sign, not known, plus those gone onto approved training or transfer to Government-supported training.

- 2012/13 to 2013/14: the economy continued to improve; the referral rate for sanctions declined, though the adverse decision rate remained unchanged (and both remained at very high levels). There was a large rise in the exits to work, and unemployment continued to fall.

Although this analysis is based purely on observational data, the association between the threat and use of JSA sanctions and labour market outcomes (for Scotland at least) is ambiguous. In the pre-recession period, when the demand for labour was relatively high and stable, increased use of sanctions was associated with a modest increase in exits to work from JSA and reductions in unemployment. In the years 2008/09 to 2011/12, with stagnating demand, there was a dramatic increase in referrals and adverse decisions alongside falling exits to work and rising unemployment. It might also be asked why a dramatic rise in the use of sanctions and the introduction of more severe penalties in 2012 was not matched by a proportionate increase in exits from JSA into work. This is concerning given that the Institute for Fiscal Studies has noted that sanctions 'affect people who are likely to have little or no private income, and are therefore towards the bottom of the income distribution'.<sup>28</sup> NHS Health Scotland will be publishing further work on this, investigating trends in JSA sanctions and labour market outcomes, later in 2015/16.

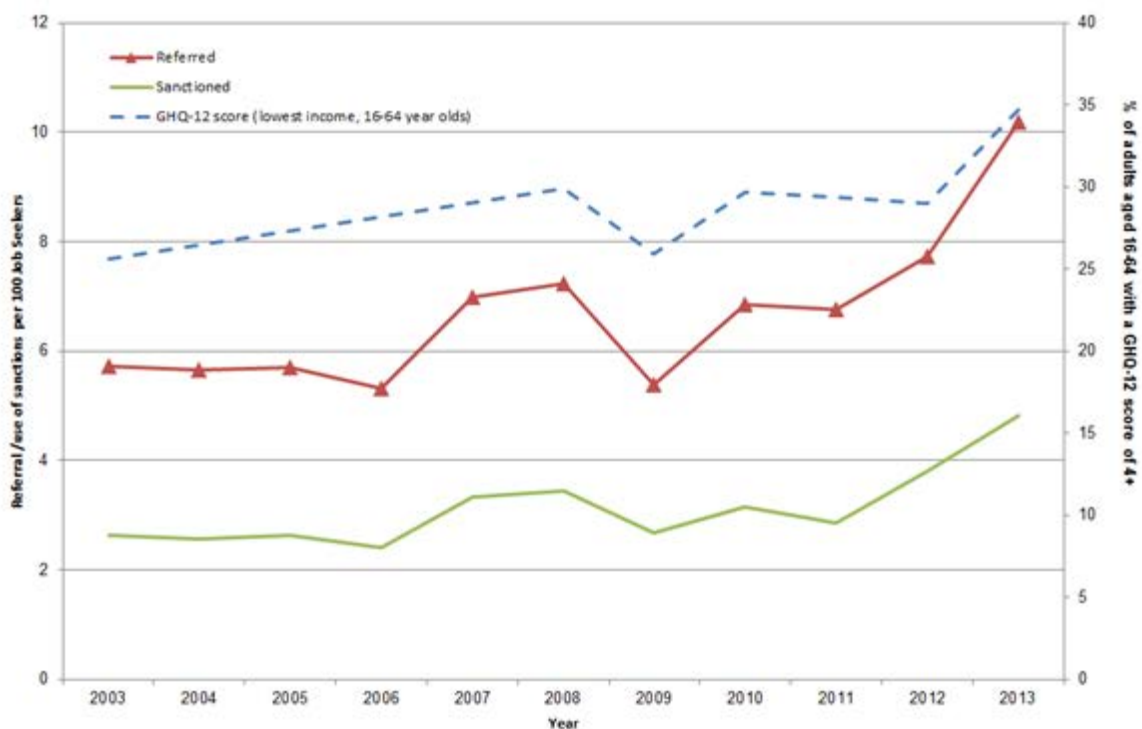
**Figure 12:** The threat and use of JSA sanctions, estimated off-flows from JSA to work and ILO unemployment rates: Scotland, 2000/01 to 2013/14



Sources: DWP Stat-Xplore; claimant count; Annual Population Survey (October–September).

The relevance of this for health inequalities is illustrated in **Figure 13**. This shows the time trends in referral/adverse decision rate on JSA sanctions in Scotland, alongside time trends in possible mental health problems for working-age adults living in the lowest-income quintile households (who are more likely to be dependent on out-of-work benefits). Possible mental health problems are measured by scores on the 12-question. A higher proportion of adults with a GHQ-12 score of 4+ would indicate a higher prevalence of possible mental health problems. Periods where a stricter use of sanctions operated (more referrals/adverse decisions and/or tougher penalties) were associated with periods of worsening mental health among low-income, working-age adults.

**Figure 13:** Referral/adverse decision rate for JSA sanctions and percentage of working-age adults in lowest-income quintile with a GHQ-12 score of 4+: 2003–13



Sources: Scottish Health Survey; DWP Stat-Xplore; Claimant count. Jan–Dec annualised average for sanctions/adjusted claimant count.

## Summary

The latest data suggest that economic output in Scotland was returning to pre-recession levels in 2013/14. Employment rates are also rising, having returned to pre-recession levels for women, though not yet for men, by 2014. Perceived financial difficulties lessened for most households from 2011/12.

However, the improvement in living standards for most households remained incomplete by 2013/14: a lack of hours (through increased involuntary part-time working), increased self-employment and little or no growth in earnings meant that incomes remained below pre-recession levels (and only the highest income group

saw a substantial increase in their incomes in 2013). It is also unclear to what extent jobs created since the recession meet the Marmot Review principles of 'good work': protecting people and their families against risks to their physical and mental health, poverty and insecurity, and offering opportunities for personal development and balancing work–life responsibilities.<sup>29</sup>

The number of people claiming out-of-work benefits has fallen since 2012, though this may not translate into moves into employment for all. The association between increased JSA sanctions and labour market outcomes, independent of changes in labour market demand, remains ambiguous. Periods where sanctions were used more intensively and/or the penalties associated with sanctions were more severe are associated with higher rates of mental health problems among low-income, working-age adults.

The decline in household incomes among the bottom three deciles predates the recession: they had experienced declining or stagnant incomes for almost a decade by 2013. This might suggest that pre-recession income trends, as well as the recession and changes to the social security system, have had a cumulative effect on lower-income households. Inequalities in labour market opportunity and financial resources, by geography, household type and individual socio-economic status, remain persistent.

## 3.3 Health and health inequality outcomes

### Introduction

The baseline report identified a number of health and health inequality outcomes associated with social security changes and the economic context, including: heart disease, respiratory disease, obesity, mental health and wellbeing, suicide, alcohol and drugs misuse, excess winter mortality, health inequalities, violence, HIV, tuberculosis and road traffic accidents (RTAs). Mechanisms by which these take place include: increased fuel and food poverty, psychological impacts of unemployment and job loss, income shocks and increased insecurity. There may also be positive changes to health, for example reduced RTAs due to lower levels of economic activity.<sup>1</sup> This section describes trends in these outcomes using the latest available data.

In the absence of individually linked data,<sup>j</sup> we have focused in this report on the working-age population (adults aged 16–64) and, where possible, disaggregated trends by measures of socioeconomic status (equivalised household income quintile or SIMD quintile) in order to increase the sensitivity of the measures to detect changes among those populations most likely to have been exposed to changes. Pensioners are likely to have been less directly affected by recession and changes to social security, both because they are less reliant on earnings and employment for their income<sup>k</sup> and because social security spending on pensioners has been (partially) protected. Showing separate trends by socioeconomic status is also relevant, since it has been the most disadvantaged among the working-age population who were most exposed to the adverse effects of the recession and its aftermath, and who were and are most reliant on state benefits affected by freezes in their value, reduced entitlement and increased conditionality.<sup>30</sup>

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<sup>j</sup> Anonymised data linking individual social security, tax and health records are not currently made available to allow the impacts to be assessed directly.

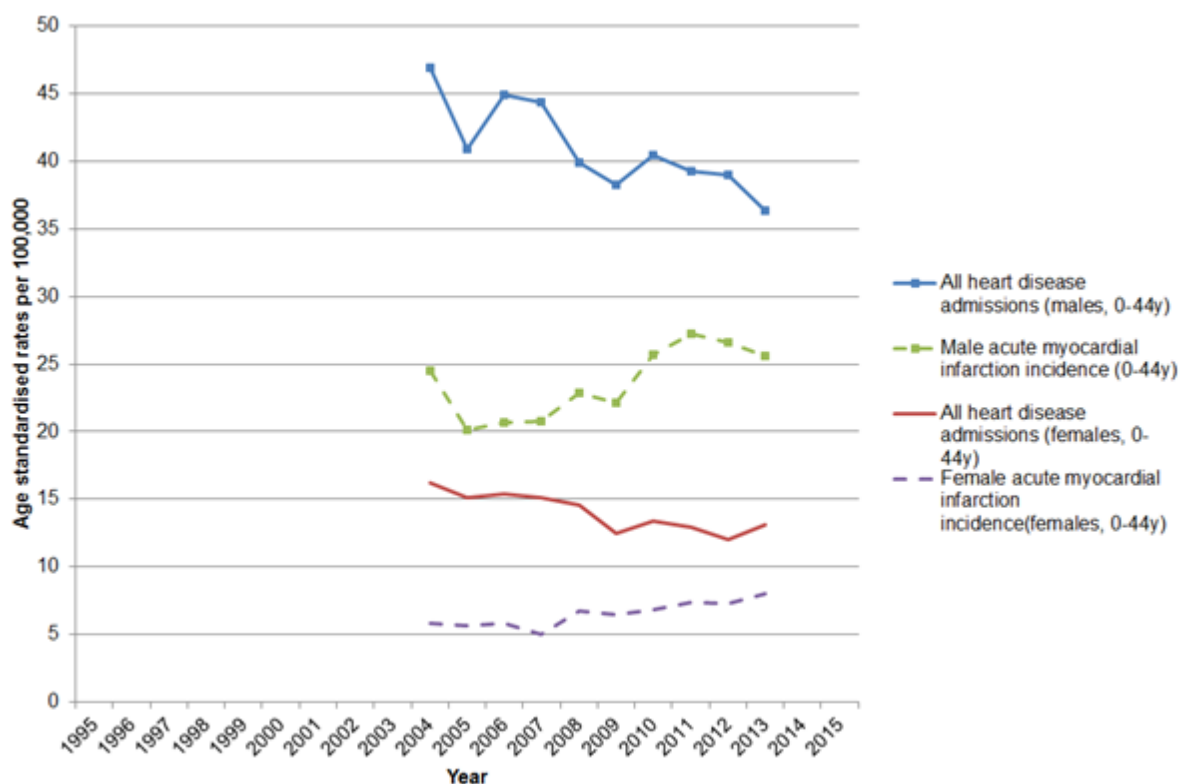
<sup>k</sup> However, pensioners may have been indirectly affected, because of transfers of money (in both directions) between retired and non-retired households, and also because of greater participation of the over-65s in the labour market.



## Heart disease trends

The incidence of heart disease among young adults (aged 0–44 years) in Scotland declined in both men and women from 2004 (**Figure 14**). The incidence of myocardial infarction (heart attack) increased for both genders between 2007 and 2011, before stabilising at a higher level. However, this change is likely to be partly artefactual, reflecting an improvement in the method used for diagnosing heart attacks introduced in 2007.<sup>1</sup>

**Figure 14:** Trends in new cases of myocardial infarction (heart attack) and all cases of coronary heart disease among males and females (0–44 years): Scotland, 2004–13

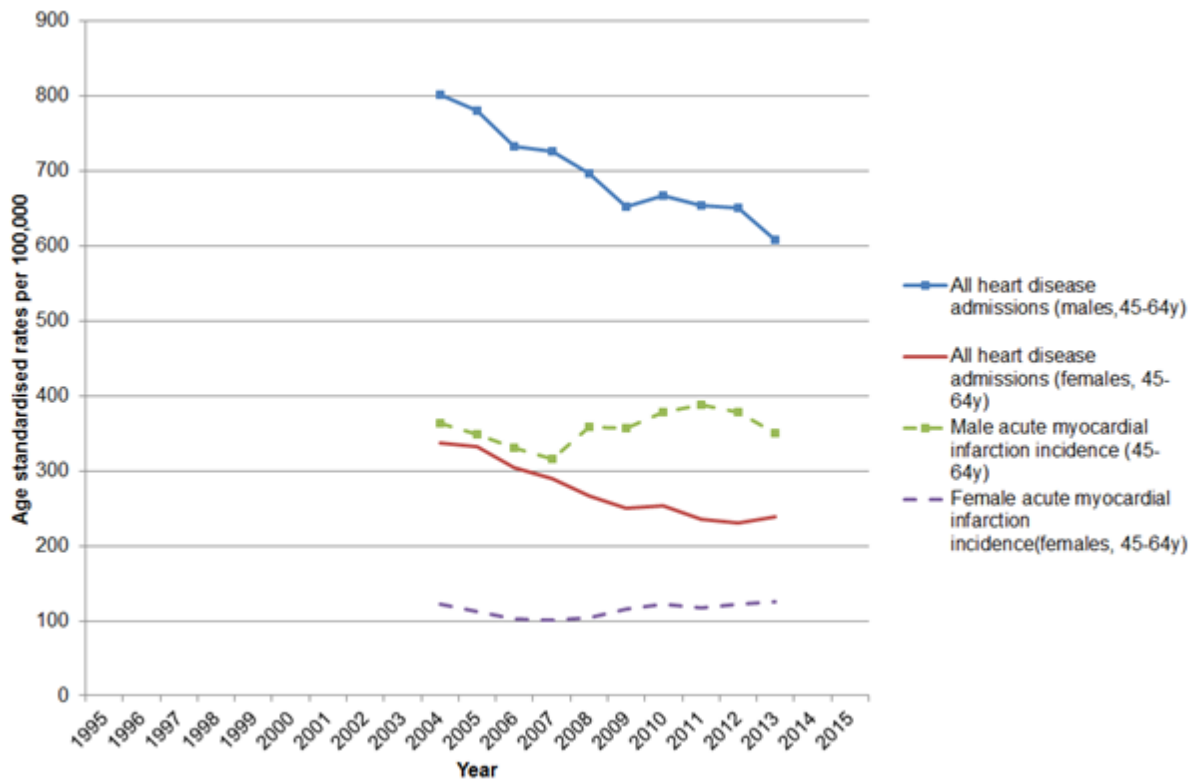


Source: Information Services Division, NHS National Services Scotland

**Figure 15** shows the trends for older working-age adults (aged 45–64 years). Patterns are similar to the younger age group, showing declines in all heart disease admissions and increases in the incidence of heart attack admissions, though again the rise in the latter could be attributable to improved diagnosis.

<sup>1</sup>For more information, please see: <https://isdscotland.scot.nhs.uk/Health-Topics/Heart-Disease/Publications/2015-01-27/2015-01-27-Heart-Disease-Report.pdf?918215514>

**Figure 15:** Trends in new cases of myocardial infarction (heart attack) and all cases of coronary heart disease among adults (45–64 years): Scotland, 2004–13

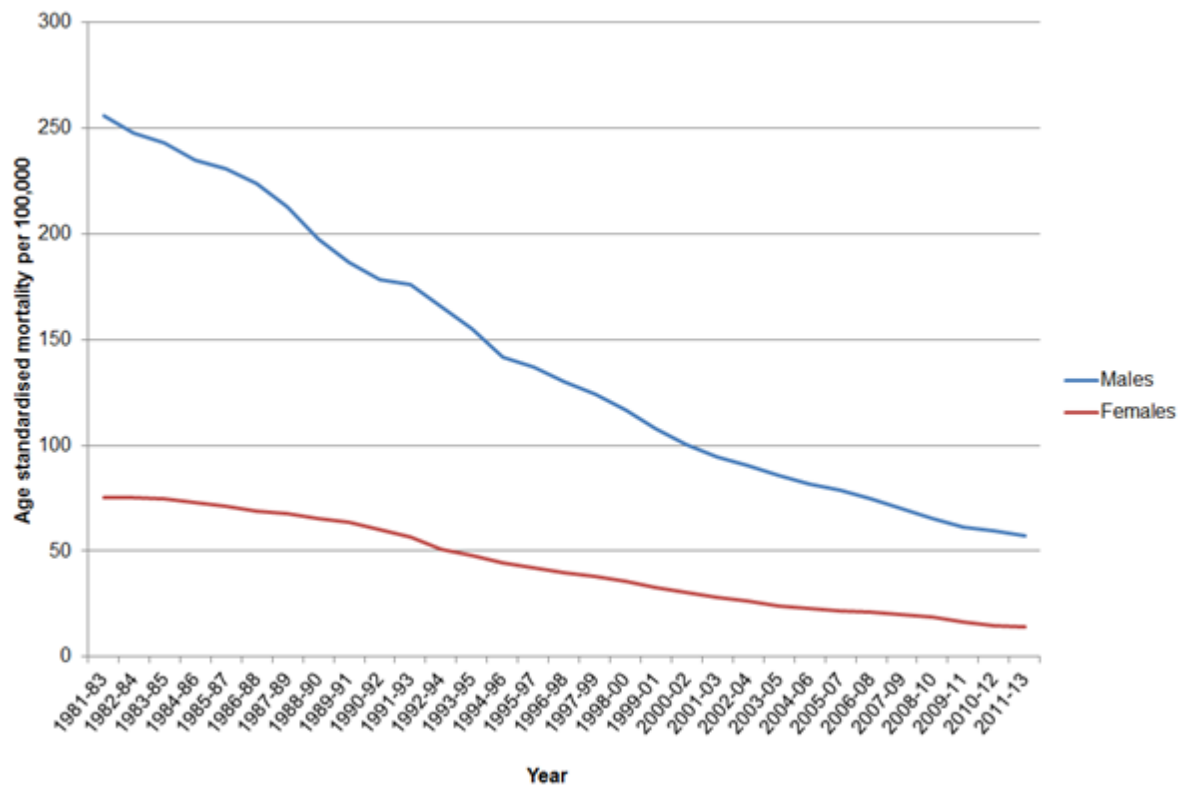


Source: Information Services Division, NHS National Services Scotland

Trends in working-age mortality from coronary heart disease are shown in **Figure 16**.<sup>m</sup> They show a rapid decline for both men and women in Scotland from the late 1980s, though this appears to have stalled since 2009–11. Trends by SIMD quintile are more volatile and should be treated with caution, but suggest this recent slowing in the downward mortality trend was seen among all deprivation quintiles but was more marked among more deprived groups (**Figure 17**).

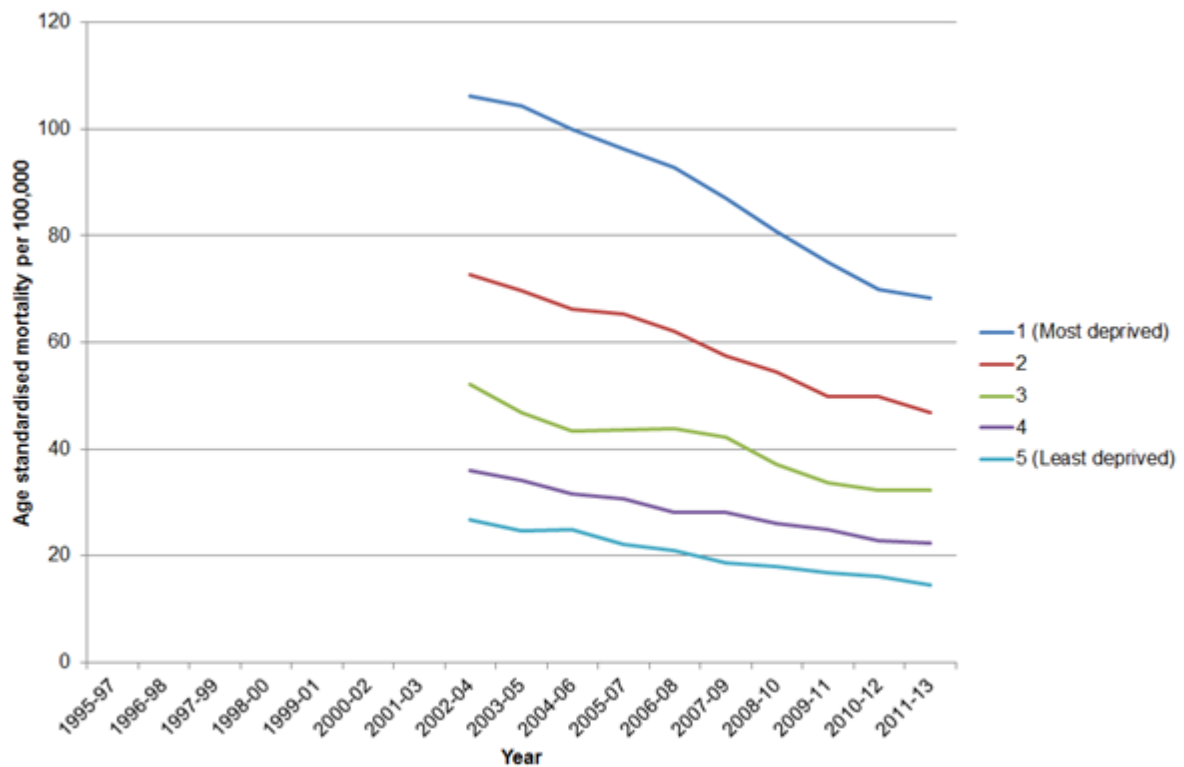
<sup>m</sup> All mortality rates presented in this report were standardised using the 2013 European Standard Population.

**Figure 16:** Trends in mortality from ischaemic (coronary) heart disease, adults aged 15–64 years: Scotland, 1981–3 to 2011–13



Source: National Records for Scotland.

**Figure 17:** Trends in mortality from ischaemic (coronary) heart disease, adults aged 15–64: by SIMD quintile, 2002–4 to 2011–13

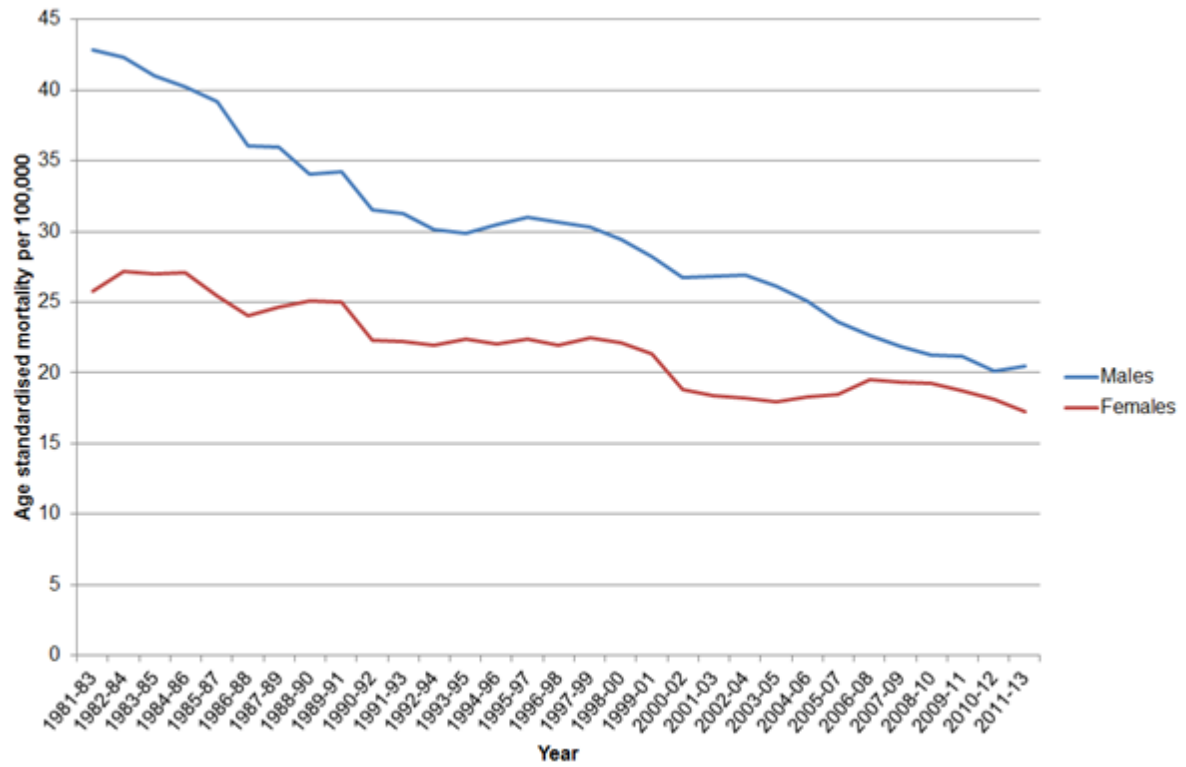


Source: National Records for Scotland.

## Respiratory diseases

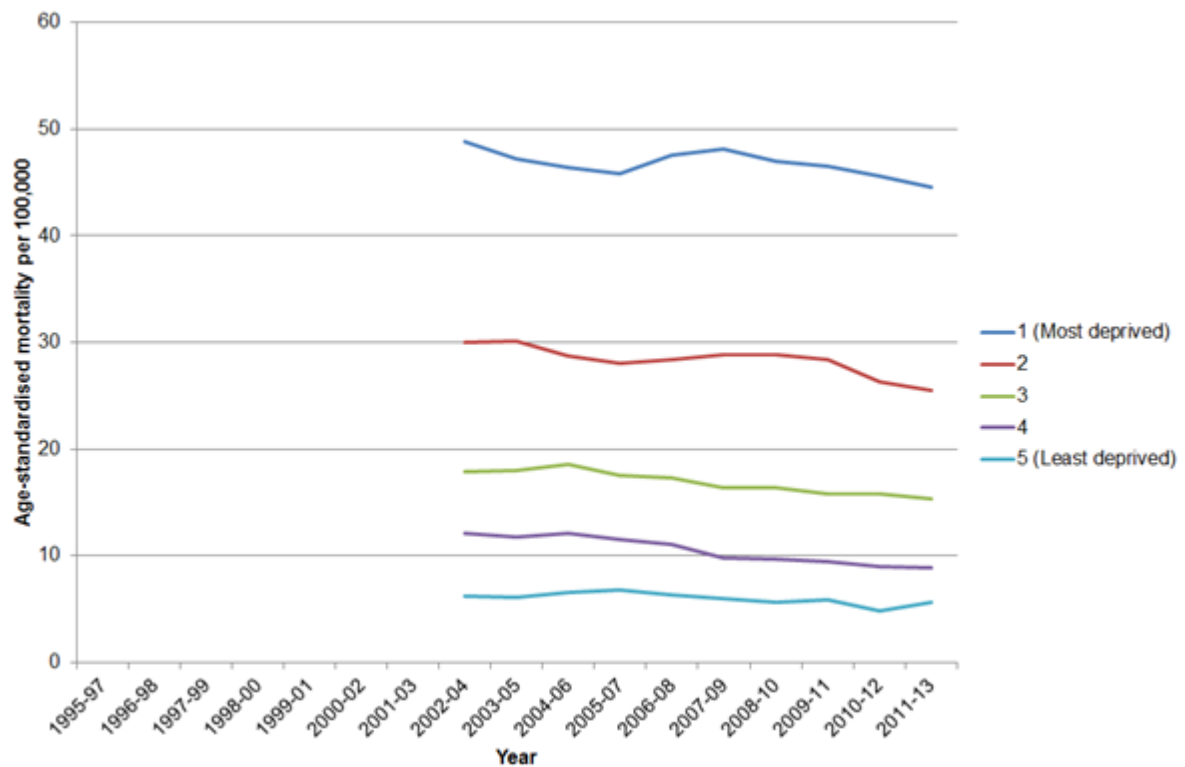
Mortality from respiratory diseases, for adults aged 15–64, shows a long-term downward trend. Although mortality rates for men remained higher than for women throughout, the gap narrowed somewhat in the years prior to the recession (**Figure 18**). There are no clear differences in trends in mortality rates by SIMD quintile, although rates increase with deprivation and are substantially higher in the more deprived groups (**Figure 19**).

**Figure 18:** Trends in mortality from respiratory disease, adults aged 15–64: Scotland, 1981–83 to 2011–13



Source: National Records for Scotland.

**Figure 19:** Trends in mortality from respiratory disease, adults aged 15–64: by SIMD quintile, 2002–4 to 2011–13

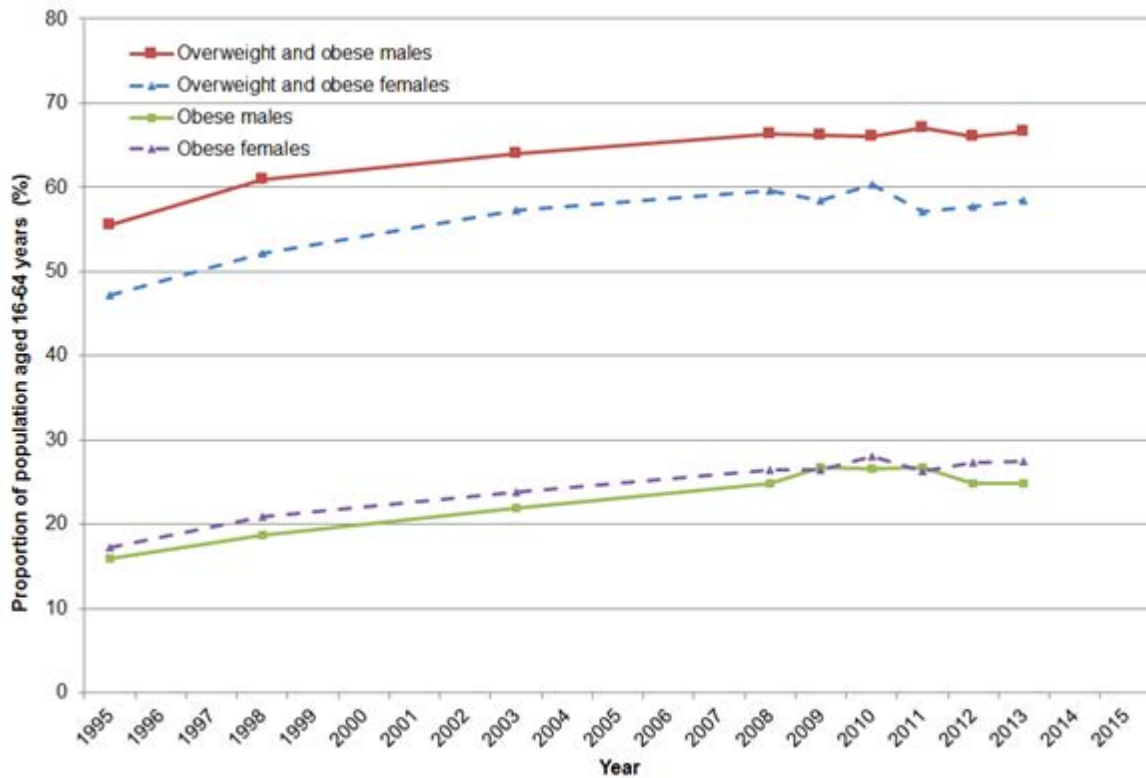


Source: National Records for Scotland.

## Obesity

Since 1995, the proportion of Scottish adults aged 16–64 who are overweight or obese has risen by more than 10 percentage points, to almost 67% for men and almost 60% for women. Over the same period, the percentage of working-age adults who are obese also increased by around 10 percentage points to almost 24% of men and 28% of women. There is evidence that the proportion of adults who are overweight or obese has stabilised since 2008 (**Figure 20**).

**Figure 20:** Trends in the proportion of working-age adults aged 16–64 who were overweight/obese and obese only, by sex: Scotland, 2003–13

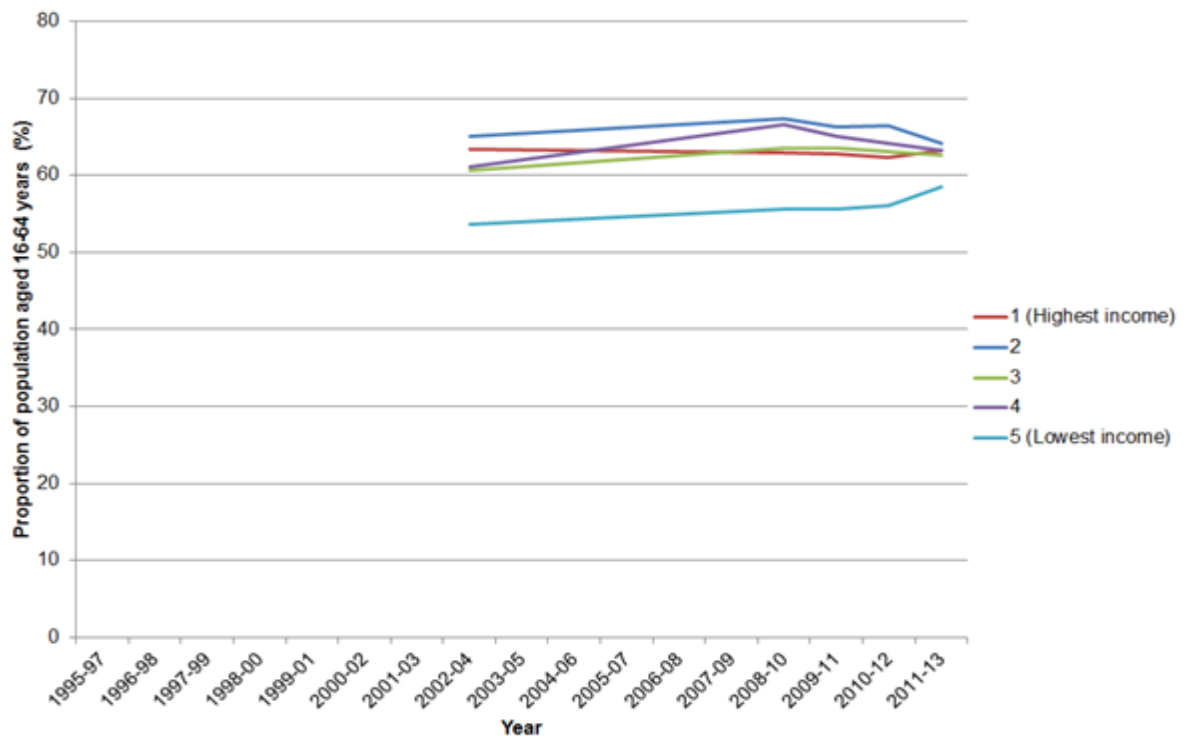


Source: Scottish Health Survey.

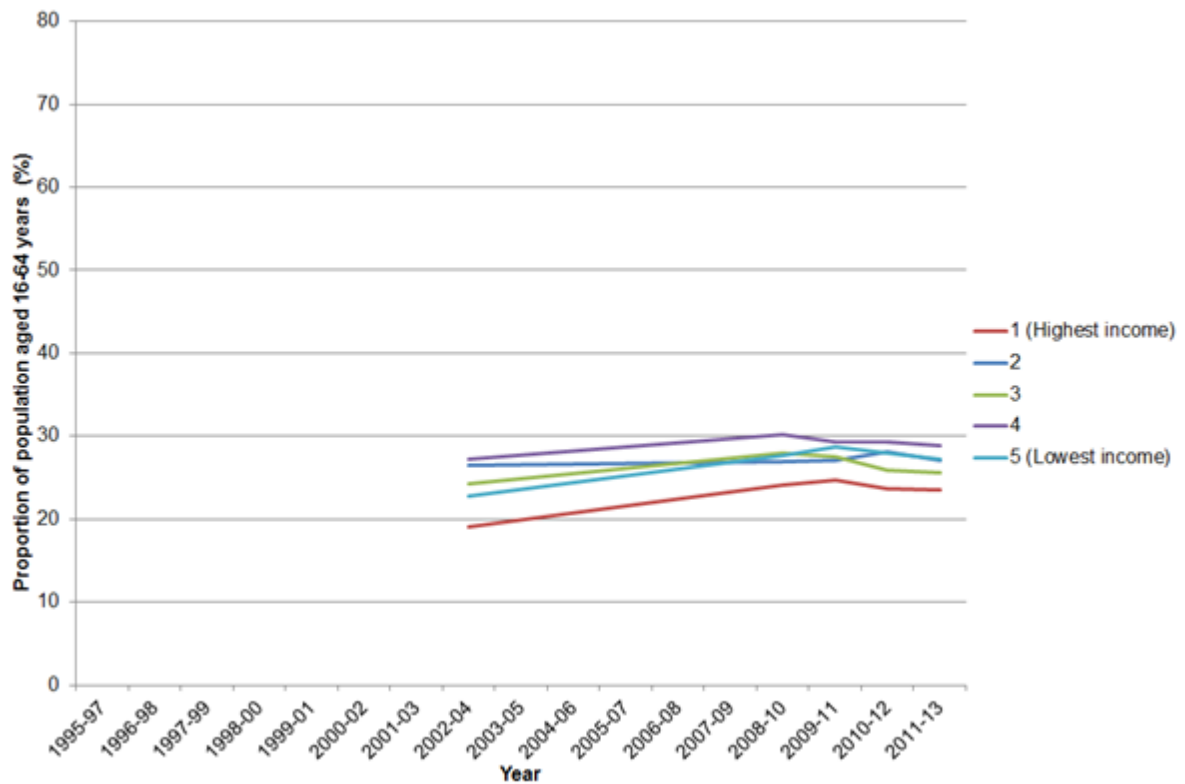
However, there is some variation in these trends by income quintile. For adults in the lowest income quintile, the proportion who were overweight/obese continued to increase after 2008, especially after 2010. By contrast, rates of overweight/obesity have fallen for those in the second-richest quintile since 2010 (**Figure 21**).

Meanwhile, obesity rates remained fairly flat across the income quintiles (**Figure 22**).

**Figure 21:** Trends in the proportion of working-age adults aged 16–64 who were overweight or obese, by income quintile: Scotland, 2003–13



**Figure 22:** Trends in the proportion of working-age adults aged 16–64 who were obese, by income quintile: Scotland, 2003–13



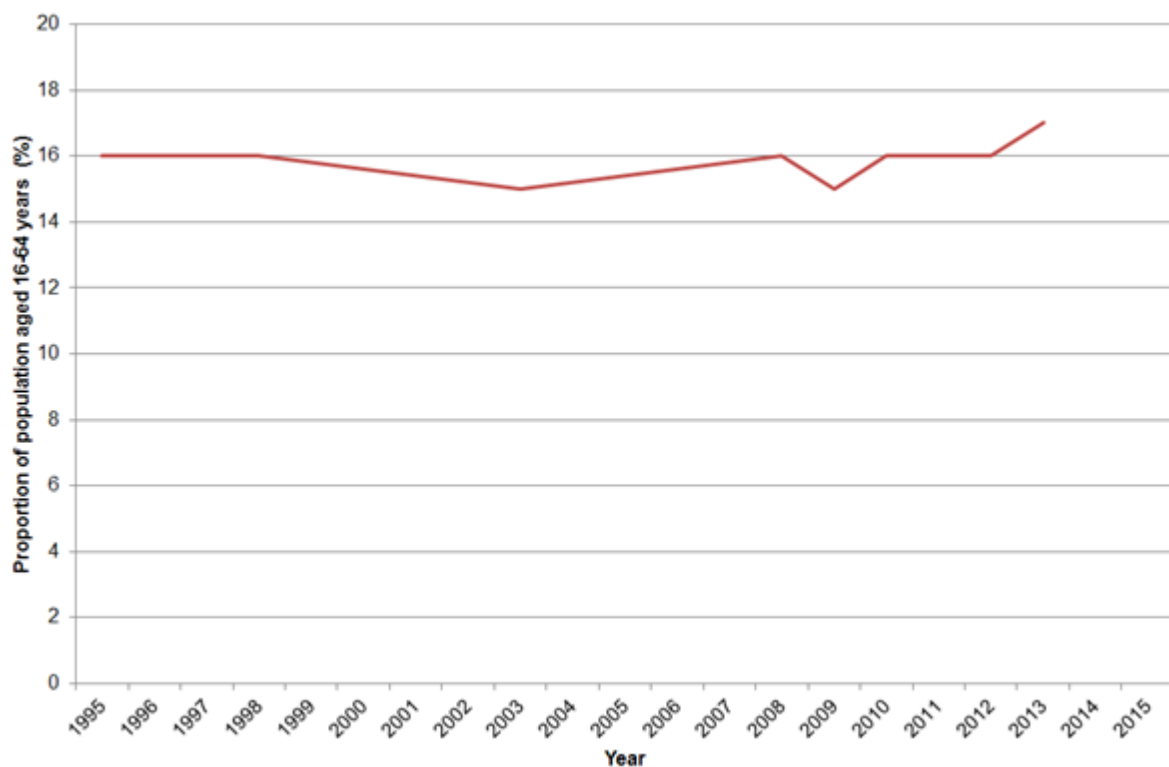
Source: Scottish Health Survey.



## Mental health and wellbeing, suicide, alcohol and drug-related mortality

**Figure 23** shows trends in the prevalence of common mental health problems, measured using the General Health Questionnaire (GHQ)-12, for adults aged 16–64 in Scotland, between 1995 and 2013. Scores of 4+ indicate a possible mental health problem. The long-term trend is one of a slight decline in possible problems between 1995 and 2003, then an increase between 2003 and 2013.

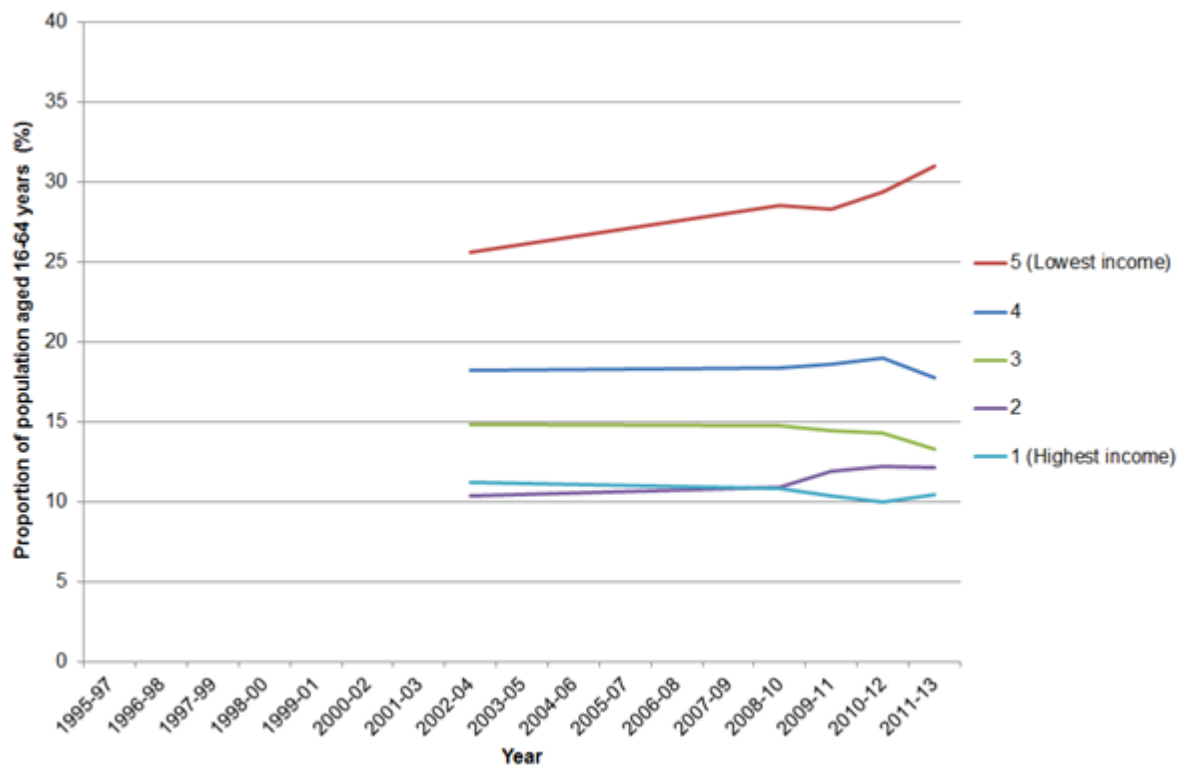
**Figure 23:** Trends in the proportion of working-age adults aged 16–64 with a possible mental health problem (GHQ-12 score of 4+): Scotland, 1995–2013



Source: Scottish Health Survey.

GHQ-12 trends are broken down by income quintile in **Figure 24**. Inequalities in mental health problems were already very wide in 2003, when around 1 in 10 working-age adults in the highest income quintile had a possible mental health problem compared with one in four in the lowest income quintile. The data suggest deterioration in the mental health of the poorest fifth of working-age adults, with increases seen between 2003 and 2008 and after 2010. There is also some evidence of temporary increases in mental health problems in quintiles 2 and 4, which may be associated with the recession (**Figure 24**).

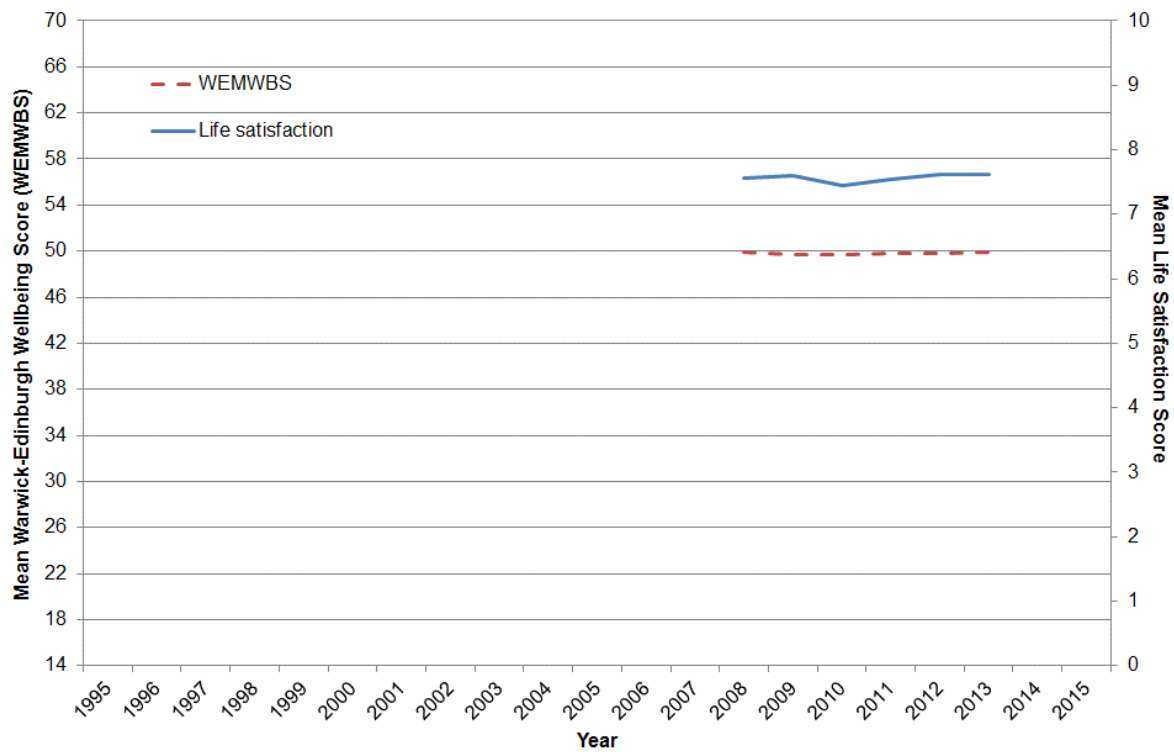
**Figure 24:** Trends in the proportion of working-age adults aged 16–64 with a possible mental health problem (GHQ-12 score of 4+), by income quintile: Scotland, 2003–13



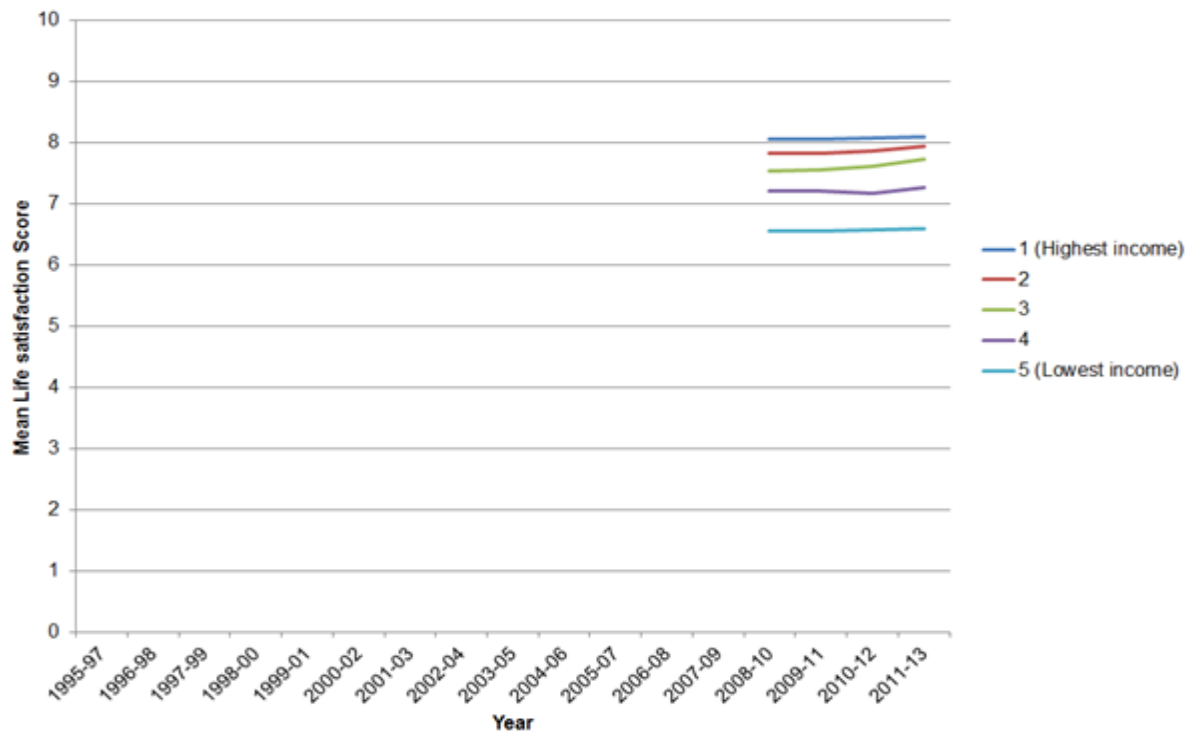
Source: Scottish Health Survey.

Since 2008, the Scottish Health Survey has also collected data on two positive measures of mental health: wellbeing (monitored by the Warwick–Edinburgh Mental Well-Being (WEMWBS) score) and life satisfaction. Since 2008, for all adults aged 16–64 both measures have remained unchanged, both in aggregate and in terms of inequalities by income quintile within them (**Figures 25 to 27**).

**Figure 25:** Trends in the mean life satisfaction and WEMWBS scores, working-age adults aged 16–64: Scotland, 2008–13

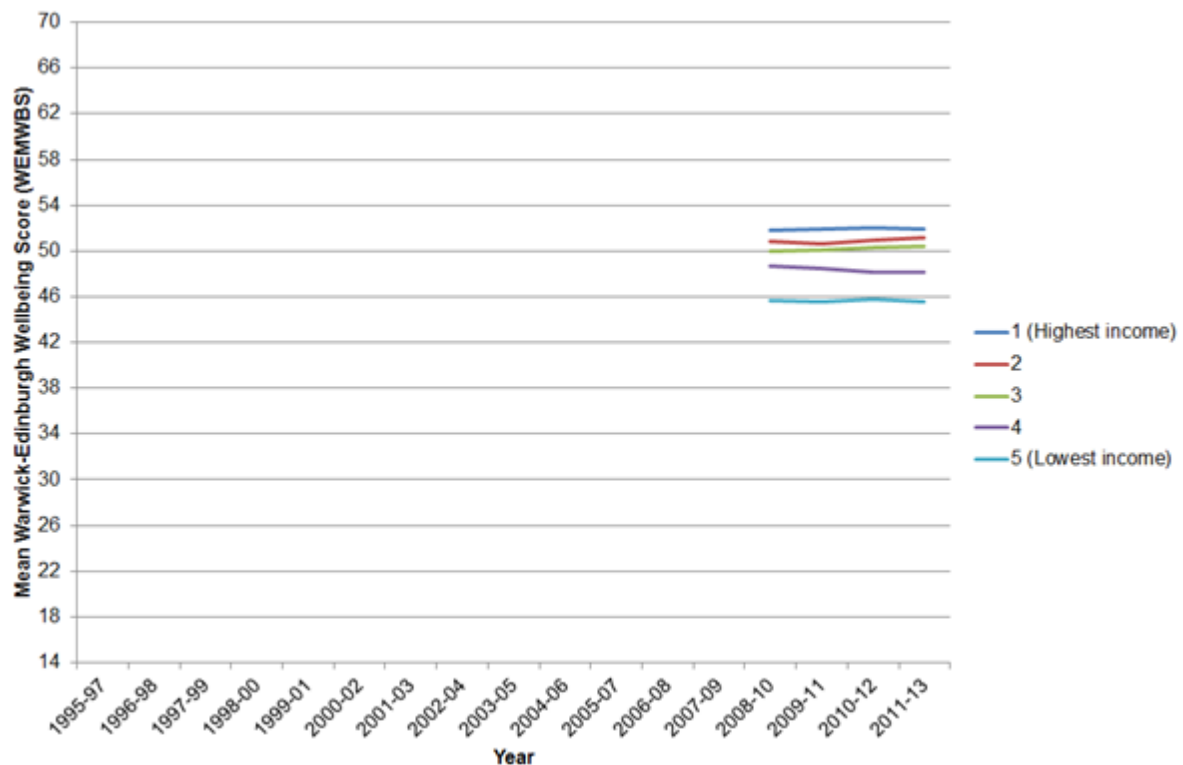


**Figure 26:** Trends in the mean life satisfaction score for working-age adults aged 16–64, by income quintile: Scotland, 2008–13



Source: Scottish Health Survey.

**Figure 27:** Trends in the mean WEMWBS score for working-age adults aged 16–64, by income quintile: Scotland, 2008–13

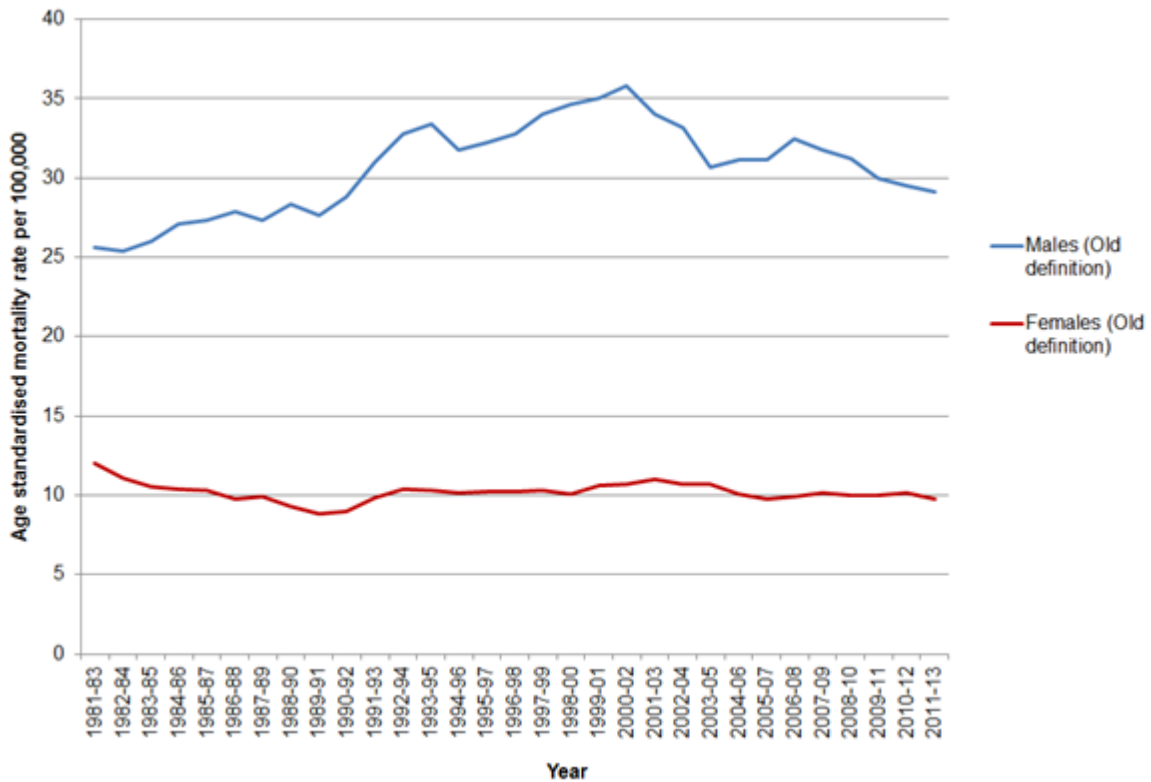


Source: Scottish Health Survey.

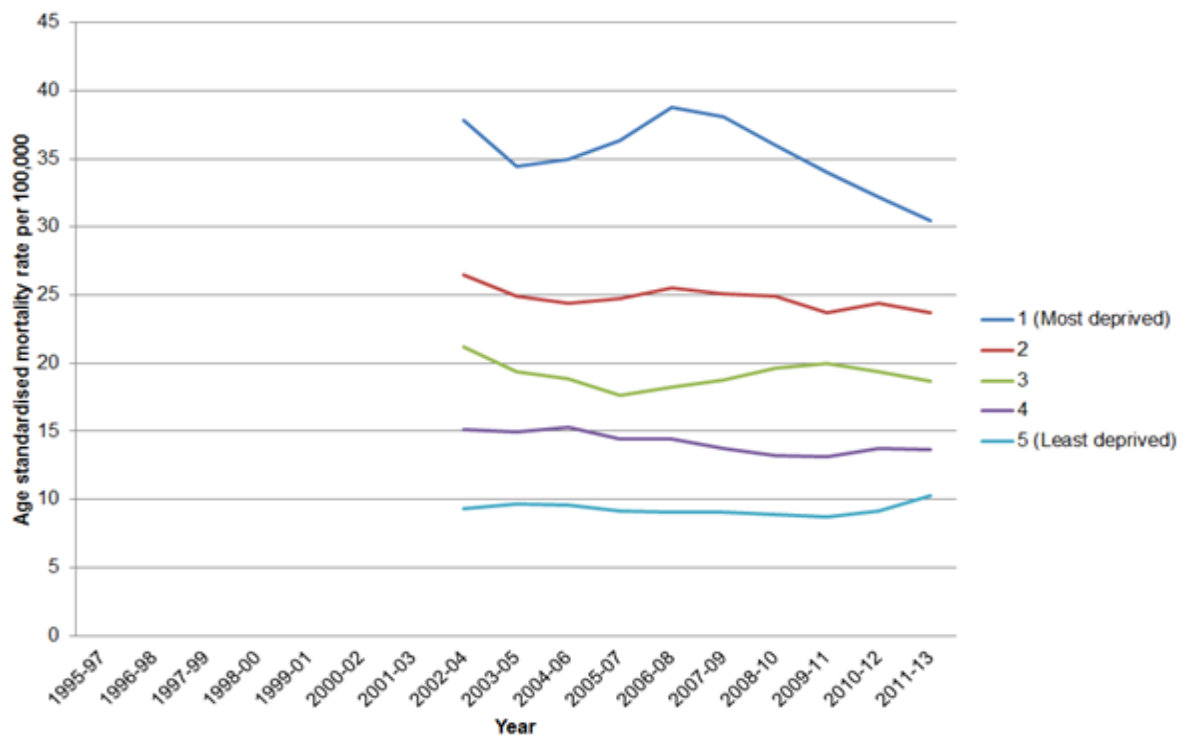
**Figure 28** shows the trends in mortality from probable suicide in Scotland from 1981 among working-age adults (using the old coding rules for continuity over time).<sup>n</sup> Mortality from suicide remains much higher for men than for women. For males, deaths from probable suicide increased throughout the 1980s and 1990s, to peak in the early 2000s. They subsequently fell back and have fluctuated without a clear trend since the mid-2000s. For females, rates of mortality from probable suicide fell in the early 1980s and have shown little change over time since then. Trends in suicide-related deaths for working-age adults in the most deprived quintile declined steadily between 2007–09 and 2011–13, but remained stable for those in other SIMD quintiles.

<sup>n</sup> The definition of probably suicide changed in Scotland in 2011 to include some deaths from 'mental and behavioural disorders due to psychoactive substance use'. Results shown here use the old coding rules for consistency over time.

**Figure 28:** Trends in mortality from probable suicide, adults aged 15–64: Scotland, 1981–2013



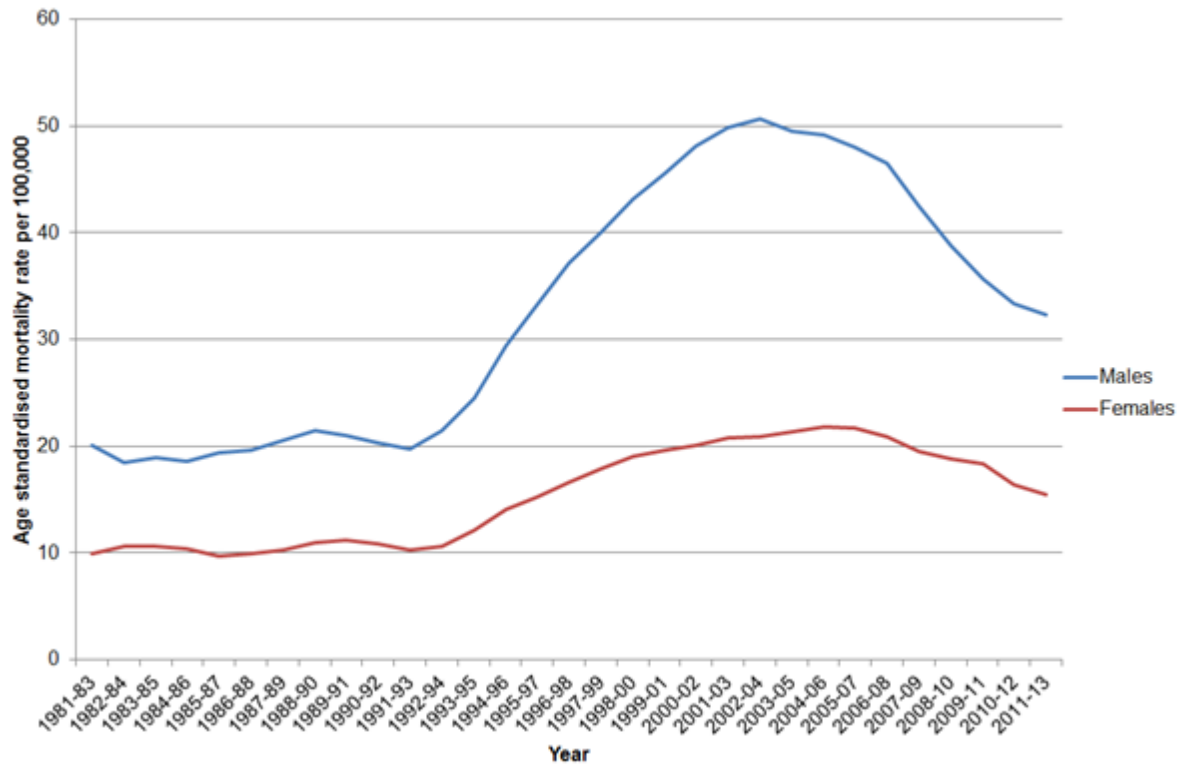
**Figure 29:** Trends in mortality from probable suicide, adults aged 15–64: by SIMD quintile, 2002–13



Source: National Records for Scotland.

Alcohol-related mortality for working-age men and women in Scotland rose sharply during the 1990s, fluctuating around a high peak between 2002 and 2006. It has fallen substantially since then, especially for men (Figure 30). The long-term trends were mainly driven by steep falls in working-age alcohol-related mortality for adults living in the most deprived SIMD quintile (Figure 31).

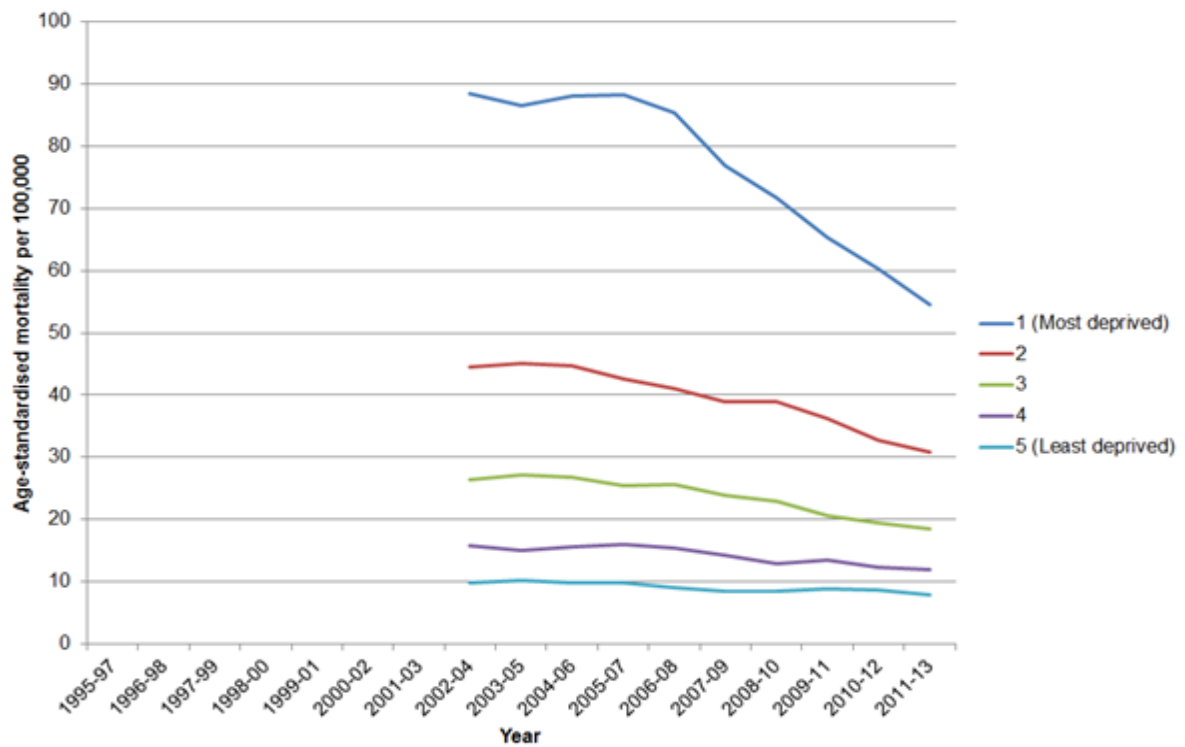
**Figure 30:** Trends in mortality from alcohol-related mortality, adults aged 15–64: Scotland, 1981–2013



Source: National Records for Scotland

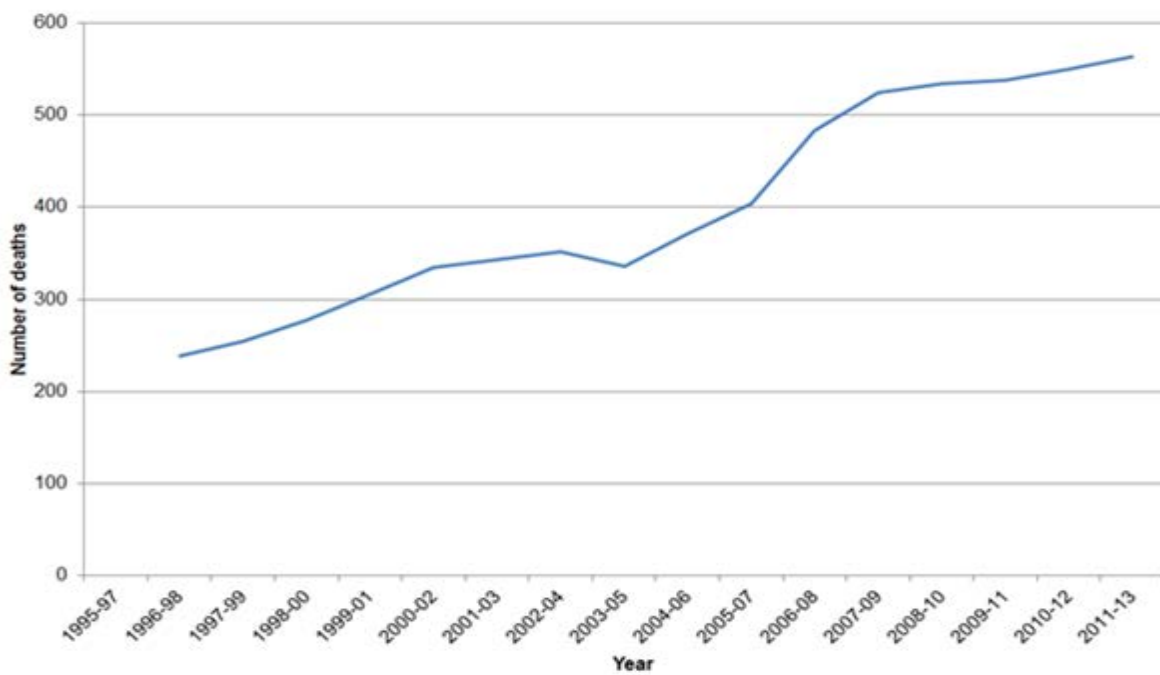
Deaths from drug-related mortality, using the official NRS definition, increased steadily between 1996 and 2001 and then again from 2005 to 2008. They have subsequently fluctuated at a very high level of between 480 and 580 deaths a year (Figure 32).

**Figure 31:** Trends in alcohol-related mortality, adults aged 15–64: by SIMD quintile, 2002–13



Source: National Records for Scotland.

**Figure 32:** Trends in crude number of drugs-related deaths, all ages: Scotland, 1996–2013

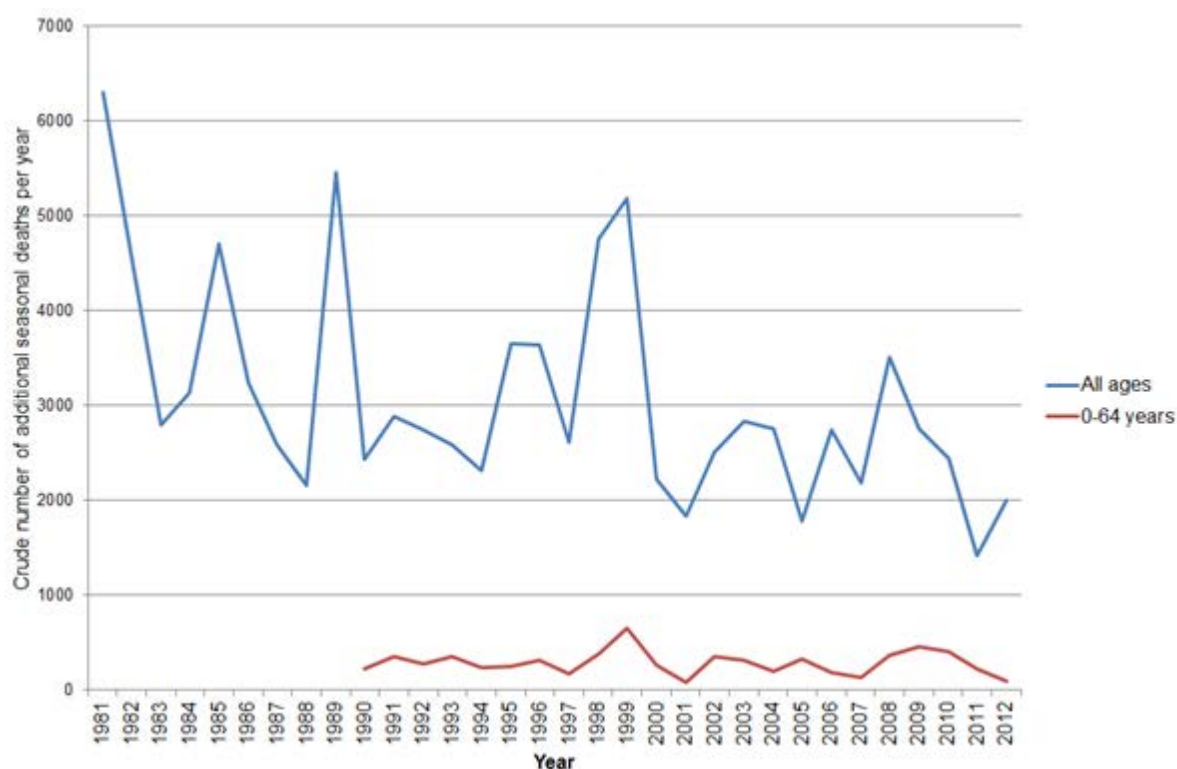


Source: National Records for Scotland.

## Excess winter mortality

**Figure 33** shows the time trend in excess winter mortality in Scotland, for the whole population and for those aged up to 65 years, between 1975 and 2013. The majority of excess winter deaths occur among those aged over 65 years, with the trend showing a decline in mortality over the period with peaks relating to influenza epidemics.<sup>31</sup> There is little evidence of a trend in excess winter mortality deaths among younger age groups.

**Figure 33:** Trends in excess winter mortality, all ages and those aged 0–64 years: Scotland, 1975–2013



Source: National Records for Scotland.



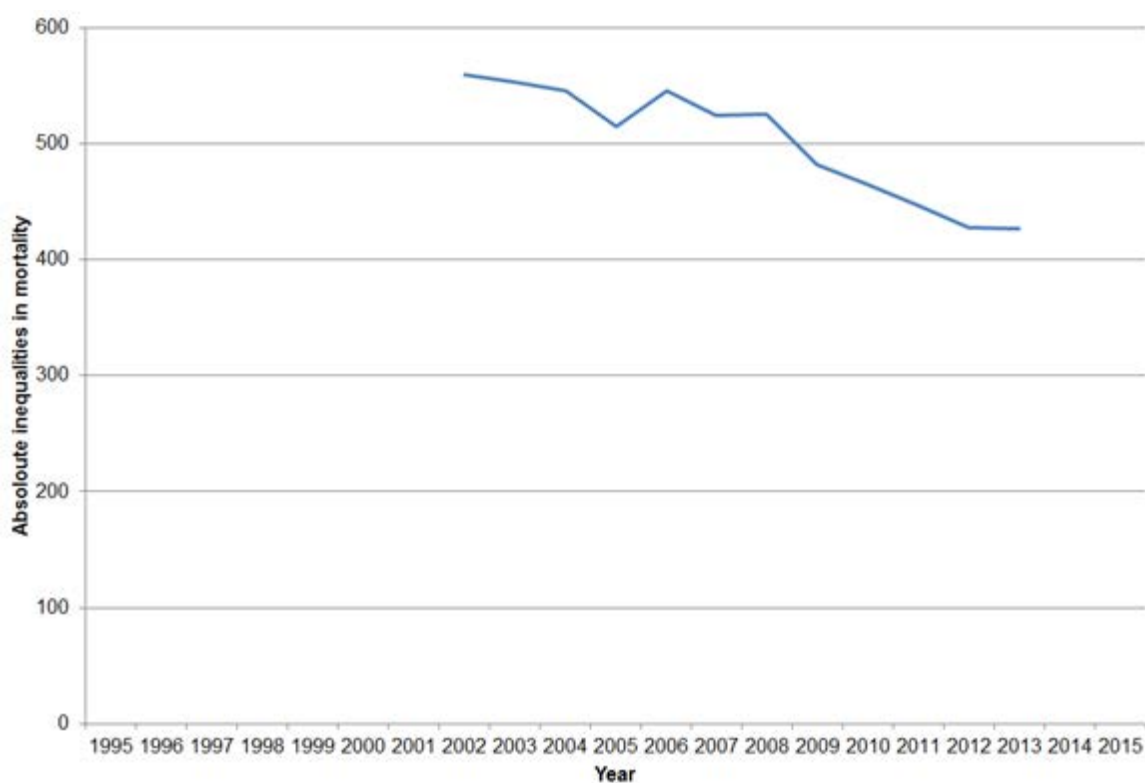
## Health inequalities

Inequalities in health can be measured in various ways. Here we use the Slope Index of Inequality (SII) and the Relative Index of Inequality (RII), applied to working-age (adults aged 15–64) mortality across the SIMD 2012 quintiles. The SII is an absolute measure which takes into account the range of mortality across all SIMD quintiles, and the hierarchical ranking of SIMD quintiles from least to most deprived. The RII is a relative measure of inequality, derived by dividing the SII by the mean standardised mortality rates for the population.<sup>32</sup>

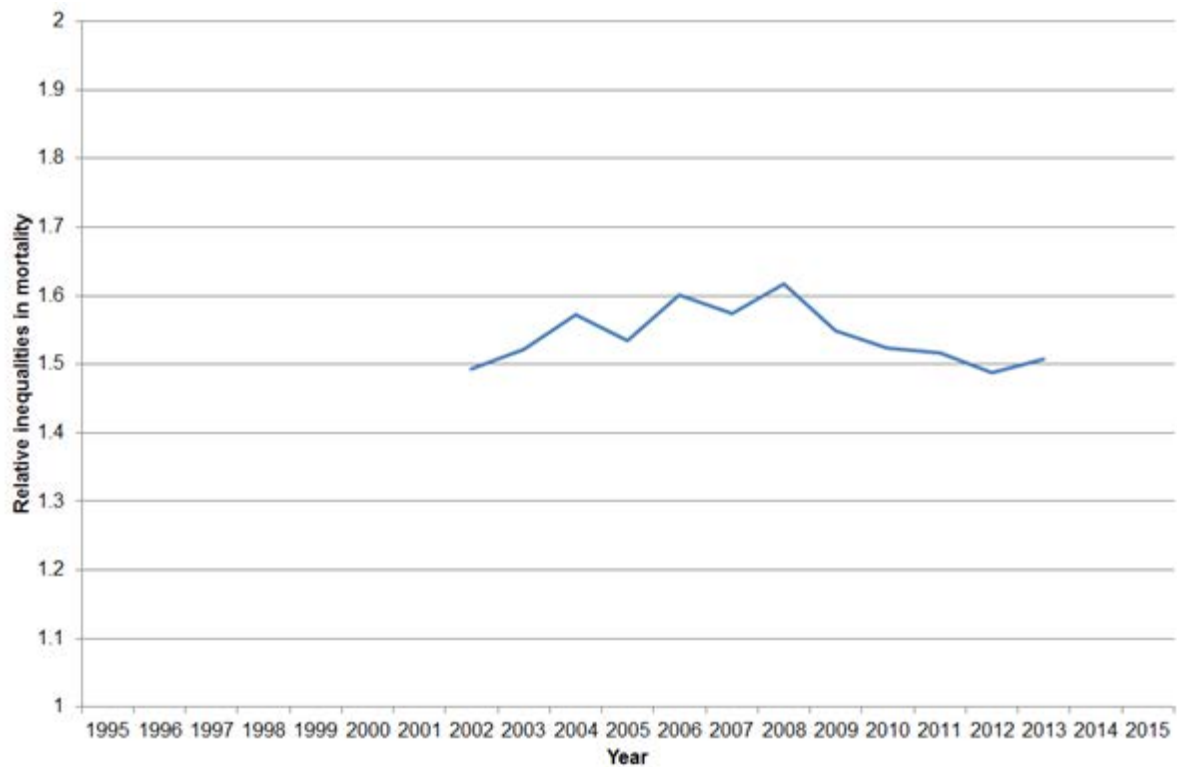
For working-age adults in Scotland:

- Absolute inequalities in all-cause mortality (measured by SII) declined until 2005, increased slightly until 2008, then declined until 2012 (**Figure 34**).
- Relative inequalities in all-cause mortality (measured by RII) increased until 2008, then declined steadily until 2012 (**Figure 35**).

**Figure 34:** Absolute inequalities in mortality, adults aged 15–64: Scotland, 2002–13



**Figure 35:** Relative inequalities in mortality, adults aged 15–64: Scotland, 2002–13



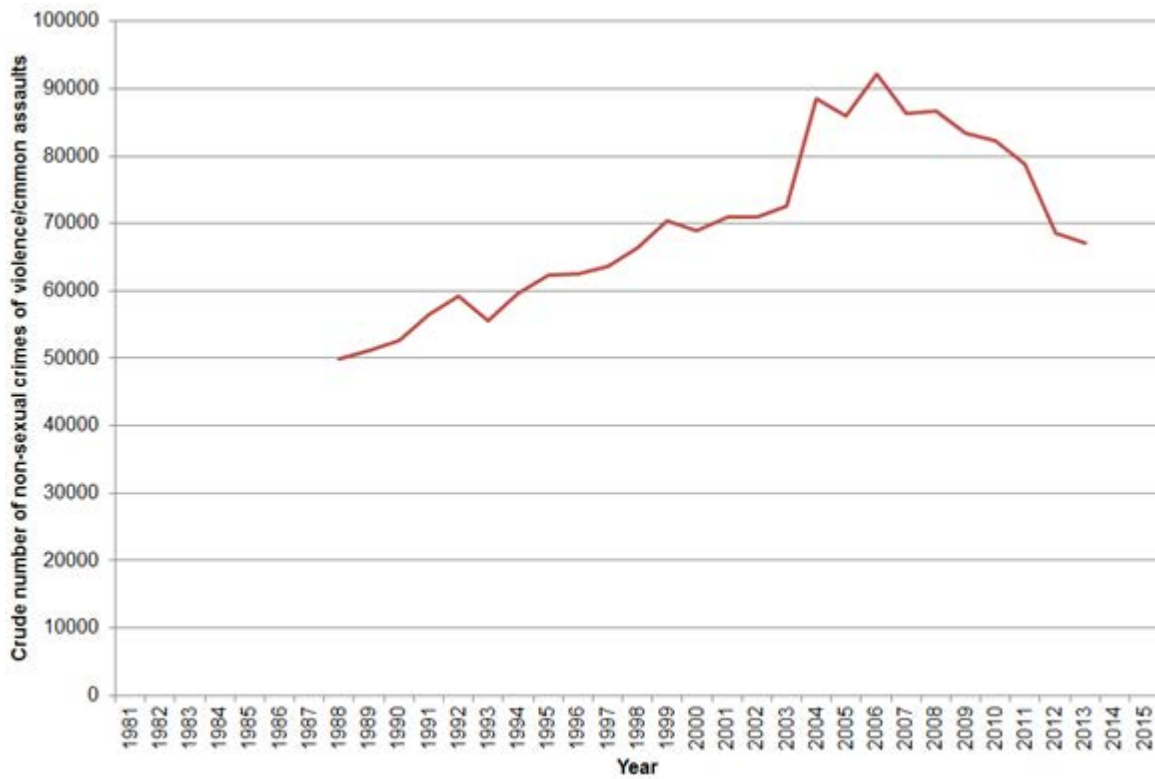
Source: NRS data; mid-year population estimates.

## Violence

**Figure 36** shows the crude number of non-sexual crimes of violence (including assault, robbery and other violent crimes) recorded by the police in Scotland over time. Recorded violence increased between 1988 and 2006. Since then violent crime has been falling year-on-year, with levels for 2013 lower than they were in 2003. Recorded crime is very sensitive to changes in practices and is likely to underestimate the true level of crime compared with population survey estimates. However, comparisons with the Scottish Crime and Justice Survey and its predecessors show a similar trend.<sup>o</sup>

<sup>o</sup> For more information see: [www.gov.scot/Publications/2014/03/9823/5](http://www.gov.scot/Publications/2014/03/9823/5)

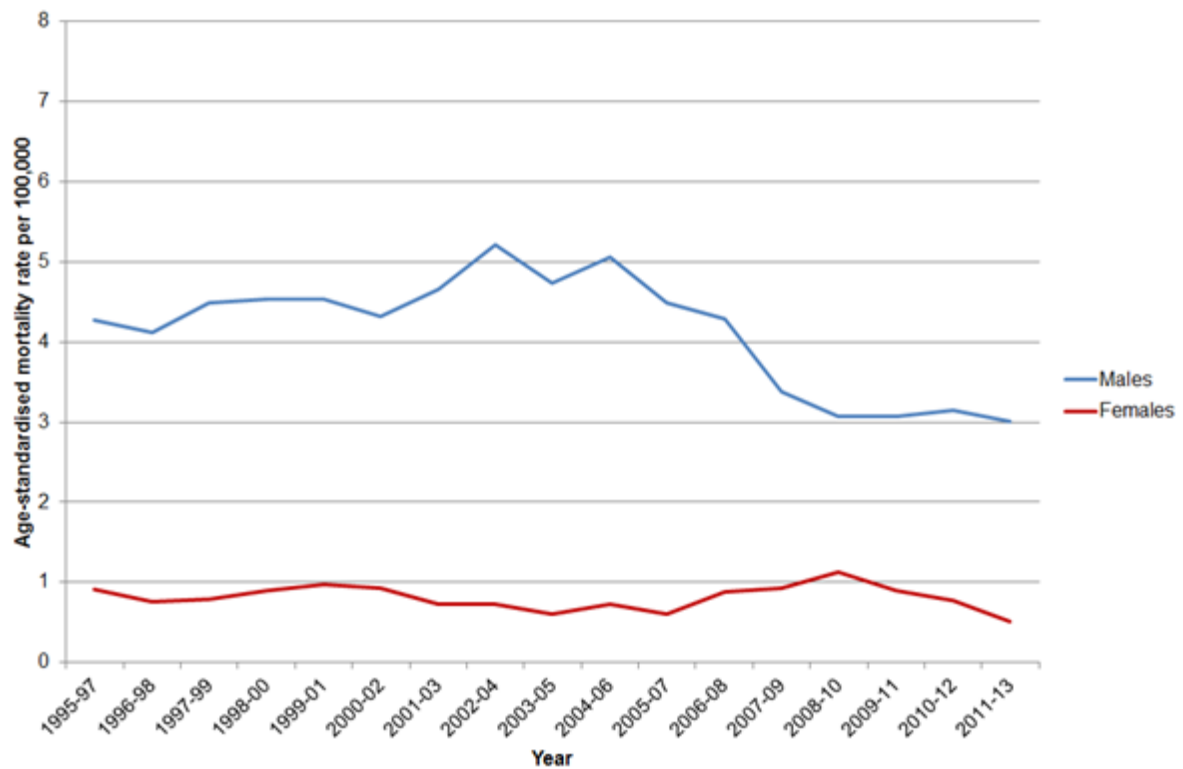
**Figure 36:** Trends in the crude rate of recorded non-sexual crimes of violence (including common assault): Scotland, 1988–2013



Source: Scottish Government.

For men, working-age mortality due to assaults fluctuated without a clear trend from 1995 before falling sharply between 2006 and 2008. Rates have remained broadly stable since then. For women, mortality rates from assault are generally low and stable throughout, with some evidence of a temporary increase between 2008 and 2010 (**Figure 37**). Much of the decline in assaults was seen in the most deprived SIMD quintile (data not shown).

**Figure 37:** Trends in mortality from assaults, adults aged 15–64: Scotland, 1995–2013

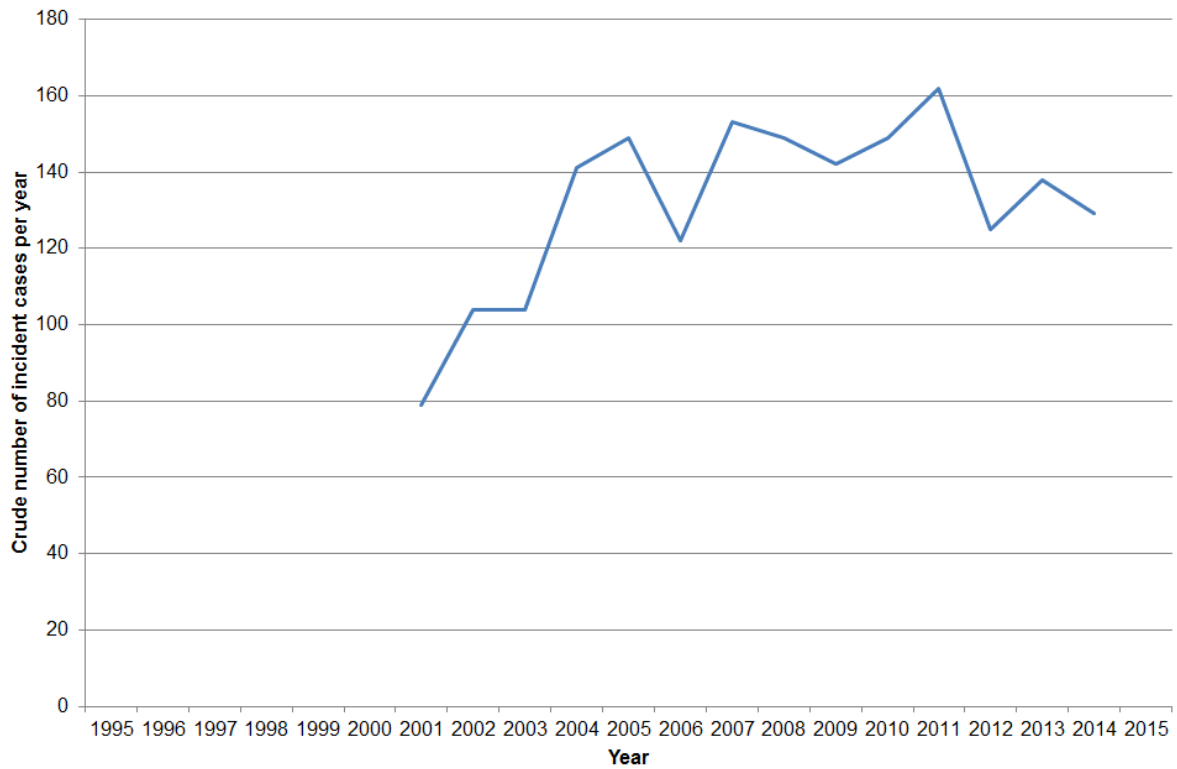


Source: National Records for Scotland.

## Human Immunodeficiency Virus (HIV) and tuberculosis

**Figure 38** shows the crude number of new cases of HIV or Acquired Immunodeficiency Syndrome (AIDS – the pattern of morbidity associated with AIDS) which are presumed to have been acquired in Scotland. The total number of cases increased between 2001 and 2011 before falling after 2011. They have fluctuated at a lower level since then.

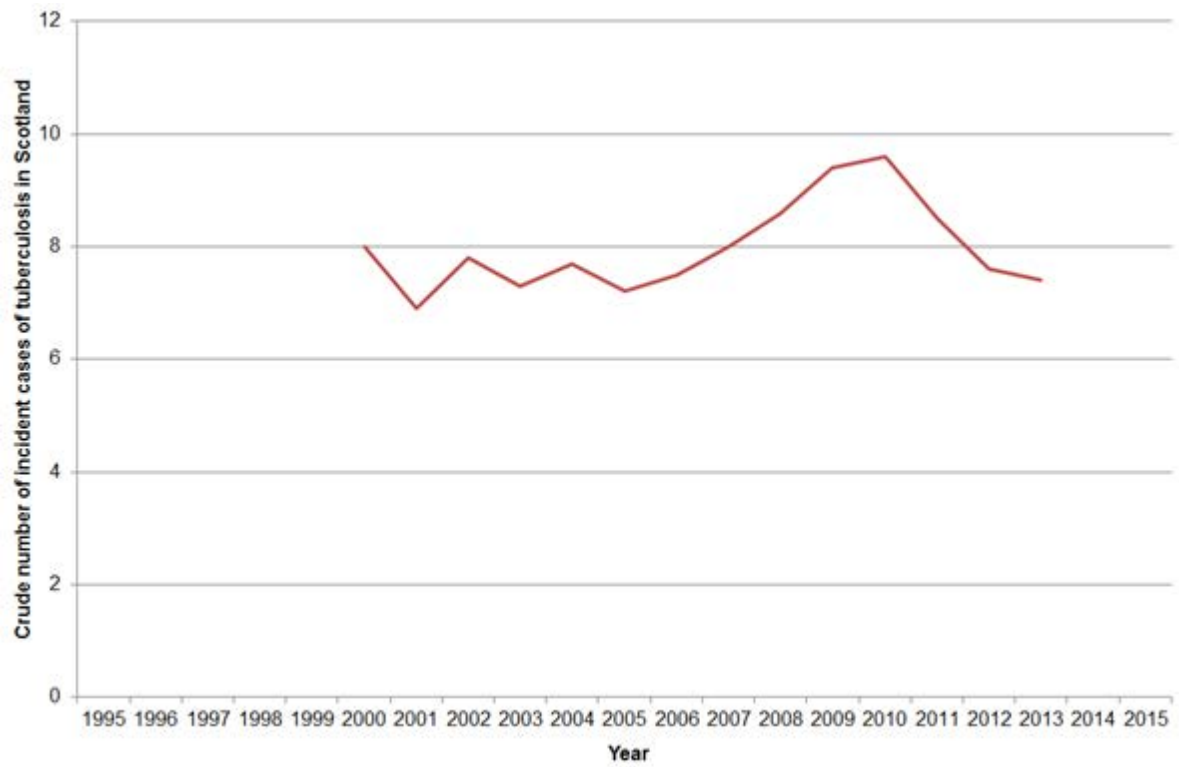
**Figure 38:** Crude number of incident cases of HIV/AIDS with a presumed Scottish origin per year (all ages, 2001–14)



Source: Health Protection Scotland.

Tuberculosis is also an infectious disease which is most commonly acquired abroad rather than within Scotland, although data are not available to break down the total number of new cases by presumed country of origin. This measure is, therefore, sensitive to patterns of immigration and international incidence rates. **Figure 39** shows that the crude rate of incident cases of tuberculosis increased between 2001 and 2010 before a subsequent sustained decline.

**Figure 39:** Trends in the crude rate of incident cases of tuberculosis in Scotland (all ages, 2000–13)

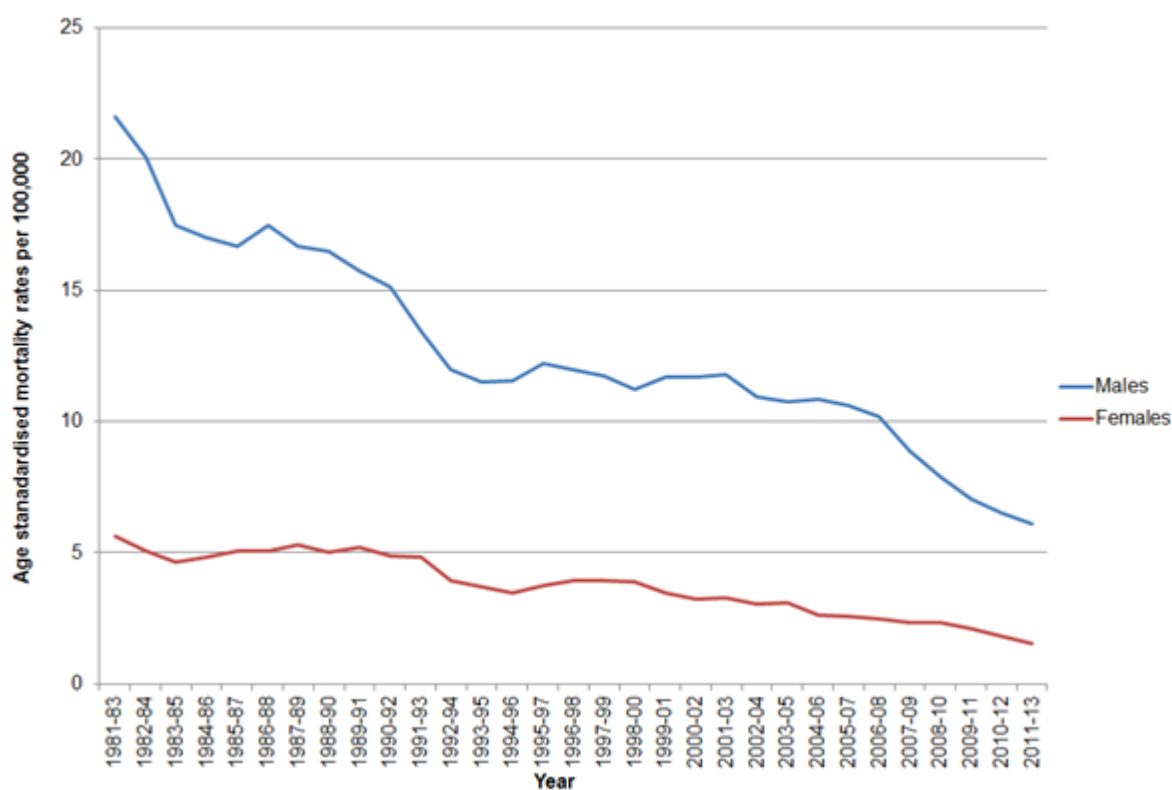


Source: Health Protection Scotland.

## Road traffic accidents

Trends in working-age mortality from RTAs reveal a number of points. While RTA deaths among working-age women show a slow, steady downward trend over time, rates for men show falls in the recessions of the early 1980s, early 1990s and late 2000, with no step back up during periods of economic recovery (**Figure 40**). The fall in RTA mortality during the 2008/09 recession was most pronounced among working-age adults living in the most deprived quintile and quintile 3 (data not shown).

**Figure 40:** Trends in mortality from RTAs, adults aged 15–64 years: Scotland, 1981–3 to 2011–13



Source: National Records for Scotland.

## 3.4 Are any groups especially vulnerable to social security reform?

This section considers the evidence on the potential impact of social security reform on subgroups of the population, based on a rapid review of literature published between 2010 and December 2014. It focuses on changes announced within the lifetime of the Conservative–Liberal Democrat Coalition UK Government (May 2010–May 2015). The search strategy and process used to screen the literature is described in the methods section. Where appropriate, it will also draw on the evidence presented so far in this report.

Overall, the literature suggests that social security reform has disproportionately affected some subgroups of the population (and will continue to do so), but the way in which this process has played out varies from group to group. However, a number of common threads emerge from the literature.

First, **the net changes to social security announced are highly regressive in nature**; that is, low-income groups are disproportionately adversely affected. Before taking the positive changes anticipated by UC into account, all income groups are net losers from the reforms, but the poorest lose proportionately more.<sup>33,34</sup> The poorest half of the income distribution experiences a net loss.<sup>35</sup> Income losses are particularly large for low-income families where at least one person in the household has a disability.<sup>36</sup> The geographic areas most adversely affected (especially the older industrial regions around Glasgow) are already among the poorest in Scotland.<sup>37</sup> In addition, the move to online delivery of social security benefits is likely to disadvantage low-income households, because they are less likely to have access to the internet from home.<sup>p</sup>

Assuming full implementation of UC and full take-up, those living in the lowest income deciles are likely to gain (on average), though their gains are predicted to be small. For the UK as a whole, 2.8m families are predicted to gain, 2m lose and 2.5m experience no change. The average weekly gains for ‘winning’ households are similar to the average weekly losses from ‘losing’ households. The bottom five income decile groups are likely to contain more winners than losers from UC, but there are substantial numbers of losers.<sup>38</sup> However, it is important to note that for many families, UC is unlikely to provide a reliable route to an adequate income as measured by the Minimum Income Standard (MIS).<sup>39</sup> There are also concerns that the introduction of UC will make managing finances more difficult, due to tight

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<sup>p</sup> *The Scottish Household Survey 2014* reports that 59% of those with an annual household income of £15,000 or less had access to the internet at home, compared with 99% of households with an income over £44,000. This poses difficulties because many of the official forms and resources associated with benefit claims (including Universal Jobmatch) are online and more difficult to navigate through smartphone technology, for example, as well as raising issues of confidentiality and privacy.



budgets and the greater likelihood that low-income households will face more volatility in their circumstances.<sup>40</sup>

Second, **the interaction of social security reforms with certain protected characteristics** (age, gender, disability, marital status and ethnicity) **means that their impact will be distributed unequally across the population.**<sup>9</sup> Where sharing housing may not be appropriate and/or housing is not available, changes to housing benefit may risk increasing 'hidden homelessness' among young people. By gender, men are at disproportionate risk of being sanctioned and losing benefits or, as a result of the stricter sanctions regime, exiting the social security system.<sup>41,42,43</sup> Women are likely to be affected through multiple mechanisms, which include: their lower incomes relative to men, making them more reliant on benefits to begin with; their role as primary caregiver (through cuts to maternity pay, pregnancy benefits, the baby element of tax credits); and reduction in expenditure on services which allow them to balance work and caring responsibilities.<sup>44</sup> There are also a number of other concerns. Some have argued that changing benefits payment from the mother to the household head may reinforce the 'male breadwinner' model, reducing gender equality and potentially increasing women's exposure to the risk of domestic abuse.<sup>45</sup> Changes to housing costs may also make it more difficult for women fleeing violence to escape their situation.<sup>46</sup>

Third, **some individuals and household types are likely to be affected by multiple changes** – for example, lone parents (low income, marital status and gender), low-income families with at least one disabled household member (low income and disability), and young adults (low income and age). Even before the economic crisis and recession, minority ethnic groups, especially women, were over-represented in the bottom income quintile. Lone-parent households will continue to be among the most severely affected by cumulative tax and benefit reforms, losing a relatively high proportion of their income whether they are in work or not.<sup>47,48</sup> Excluding any changes to childcare, some estimates suggest that more than 90% of lone parents not in employment and three-quarters of those in work will lose out once the changes have been fully implemented.<sup>49</sup> For example, a lone parent in Scotland with one dependent child is expected to lose an average of £1,770 per year, all things being equal.<sup>50</sup>

A key factor to consider is whether UC can increase employment rates and reduce poverty, particularly among lone-parent households, when it is fully implemented. UC is likely to improve the incentives for some lone parents to move into part-time work of less than 16 hours per week,<sup>51</sup> and among this group, the introduction of UC could potentially boost incomes from 40% to 70% of a 'minimum income standard'. However, even assuming a substantial increase in childcare subsidies, lone parents working more than 16 hours per week are unlikely to be better off than they would have been if the pre-2010 system had remained in place.<sup>52</sup>

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<sup>9</sup> No studies on the impact of (post-2010) social security changes by gender identity, religion or sexual orientation, which met the criteria for inclusion, were identified.

The literature also highlighted the disproportionate impact of social security reform on claimants with long-term health problems or disabilities, including families with disabled children.<sup>53,54,55</sup> There are concerns that reducing financial resources to meet the extra cost of disability will have a detrimental impact on the capacity of disabled people to meet basic social and health needs and participate (and remain) in the labour market.<sup>56,57</sup> Some estimates suggest that many will also receive lower awards once UC is introduced,<sup>58</sup> again with adverse consequences for their health.<sup>59</sup> Those with mental health problems are also more vulnerable to being sanctioned.<sup>60</sup>

**Fourth, the capacity of individuals and households to respond to these changes is constrained by circumstances.** On the basis of modelling work, only 23% of households affected by changes to housing support are likely to be able to mitigate the impacts by moving house or finding employment.<sup>61</sup> Disabled people are likely to find it especially hard to move because of a lack of suitable accommodation<sup>62</sup> and doubts have also been expressed as to how they will compensate for income reductions in the move to UC.<sup>63</sup> As mentioned above, older industrial areas of Scotland are likely to be hit hardest by benefits changes, but it is precisely these areas where labour market demand is weakest (see **Figures 7c** and **7d**), constraining their ability to offset these changes by securing work or increasing their hours. Shifts to monthly payments (under UC) may prove challenging to certain groups, including people not in work; those with a lower household income; those with lower qualifications; lone parents and social renters.<sup>64</sup> Changes to disability and incapacity benefits fail to take into account the real and persistent health problems of claimants, in some cases compounded by poverty and isolation.<sup>65</sup> Nor is it clear that they take into account the higher costs that people with long-term health problems and disabilities already face.<sup>66</sup> This situation is not eased by media representations of disabled people, especially those in receipt of benefits.<sup>67</sup> On sanctions, the literature suggests that those who are particularly vulnerable to sanctions are also the most disadvantaged. This includes people who lack work experience or who face practical barriers to work, such as not having access to a car.<sup>68</sup> This should also be considered alongside other research highlighting the primacy of structural factors (such as childcare and availability of suitable jobs) in supporting lone parents into sustainable employment.<sup>69</sup>

It is important to consider these findings within the context of devolved responsibilities in Scotland, evolving UK welfare and economic policy and changes to the labour market. Concerns over direct changes to housing costs may be less relevant to Scotland, given the decision by the Scottish Government to mitigate the policy through Discretionary Housing Payments. The limited progress on introducing UC (so far) means that its full effects have yet to be felt, though again, proposals to allow claimants to choose UC payments to be made more frequently and to continue to pay housing costs direct to landlords may partly mitigate any adverse effects. On the other hand, a number of the groups identified as being affected by multiple changes to social security (lone parents, large families) were already facing financial strain prior to the post-2010 welfare reforms being introduced (**Figure 11**). To this we should add households with at least one disabled member, whose higher poverty

rates are already known.<sup>r</sup> Young adults, who were already adversely affected by the recession in terms of earnings, incomes and employment opportunities,<sup>70</sup> also stand out as a group exposed to particular hardship, through the causal mechanisms of the sanctions regime and an increasing gap between the claimant count and unemployment (**Figure 6b**). It should also be noted that single adults are currently almost as likely as lone parents to report they are struggling financially. They are unlikely to see an increase in their income following the introduction of UC (although low-income single adults are likely to gain from an increase in the national minimum wage if they are aged 25 or older). The potential for all these social security changes to either reinforce or reduce inequalities in health, alongside future prospects, will be returned to in the discussion.

## Summary

More tightly-focused analysis of health outcome data provides some clues as to the potential impact of the recession on health. For some outcomes (notably mortality from RTAs among working-age men and, to a lesser extent, population-wide obesity and alcohol-related mortality), the recession may have had a beneficial impact on health. There are also a number of health outcomes (notably declines in suicide, alcohol-related mortality and recorded violence, and increases in drug-related mortality and worsening mental health among the poorest) where the trend pre-dates the recession. The Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) team is examining this issue in more detail in relation to alcohol-related harms.<sup>s</sup> While inequalities in some aspects of working-age health (notably all-cause mortality and deaths due to alcohol, suicide and assault) have narrowed over time, the absolute gap remains wide and for many other aspects remains stable or, in the case of possible mental health problems, appears to have worsened.

We are less able to comment on the health impact of changes to social security reforms, mainly because data cannot be linked to individuals experiencing changes in circumstances. Many reforms only became embedded in 2012/13 and we only have a single year of data on outcomes. However, the rapid review of literature highlights the regressive nature of the changes, the disproportionate impact on certain groups with already low incomes and financial resilience, and the constraints on their capacity to respond. In addition, the population data highlighting the steady rise in the proportion of overweight/obese adults in low-income households since 2010 and the continued increase in mental health problems among the lowest income quintile (the latter of which shows some association with the level of benefit sanctions) are concerning and should be monitored carefully.

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<sup>r</sup> After housing costs, 23% of people with a disabled adult in their household in Scotland were living in poverty, compared with 16% of those without a disabled adult in their household: [www.gov.scot/Topics/Statistics/Browse/Social-Welfare/IncomePoverty/CoreAnalysis/povertyanalysis](http://www.gov.scot/Topics/Statistics/Browse/Social-Welfare/IncomePoverty/CoreAnalysis/povertyanalysis).

<sup>s</sup> See: [www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx](http://www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx).

## 4.0 Discussion

### 4.1 Main findings

This report updates the baseline study on the impact of economic recovery, social security reform and recession on health in Scotland, extending the analysis to 2013/14 and, where possible, disaggregating data by socioeconomic status.

On the economic contextual factors, the picture is mixed. Since 2011/12, employment has been increasing and unemployment falling in Scotland. However, these favourable trends have not yet translated into improved living standards for all. This can partly be accounted for by relatively flat earnings and high levels of self-employment and short-time working compared with before the recession. Inequalities in earnings, household incomes and demand for labour, also present before the recession, have not been resolved. Some groups (working-age adults in the lowest income decile, single-adult and large-family households) remained particularly disadvantaged.

Social security reforms have continued and, if anything, intensified since the publication of the baseline report. The number of people claiming out-of-work benefits has fallen, driven mainly by a fall in the numbers claiming Job Seeker's Allowance. However, there is a growing gap between those claiming unemployment benefit and those defined in surveys as unemployed, especially among younger age groups. This suggests some people are exiting the benefits system without finding stable employment. Comparisons of trends in sanctions with labour market outcomes suggest this policy may be an important contributory factor.

Looking at the available health data, the combined impact from economic change and continued social security reforms is not clear-cut. The impact of the recession on health appears mixed. It was associated with falls in road traffic accident deaths for men, a pause in the long-term rise in obesity at a population level, steeper falls in inequalities in mortality, and, perhaps, consolidated falls in alcohol-related mortality. On the other hand, inequalities in health remain apparent, even in those aspects which have improved over time. From 2010, there were warning signs of a slowing of improvement in some aspects of population health, widening inequalities in some others (e.g. mental health problems), and narrowing inequalities which disadvantaged low-income groups (rising overweight/obesity among low-income adults as they 'caught up' with higher-income groups).

In many indicators, it may be premature to attribute economic or health outcomes (positive or negative) to changes in social security. However, in one area – benefit sanctions – the association between trends in mental health problems among low-income working-age adults and the level of sanction activity is striking – and deserves closer consideration.

## 4.2 Strengths and limitations

Many of the strengths and limitations highlighted in the baseline report remain valid when considering the findings of this update. The descriptive results shown are based on robust administrative sources and well-established population surveys. However, the work still has the following limitations:

- Most of the outcomes data shown here describe outcomes up to the period 2013/14 – early enough to say something about the impact of the recession, but less valuable in terms of reporting on the impact of social security reforms, many of which only came into effect in 2012/13.
- Although this update has attempted to disaggregate data and focus on the working-age population, an absence of datasets that explicitly link exposures and outcomes at the individual level limits our ability to make strong causal inferences from observational data. However, work is currently underway at the MRC/CSO Social and Public Health Sciences Unit to explore the potential of linked social security and health administrative datasets in order to answer some of the questions.
- Some of the measures used are susceptible to changes in clinical practice (e.g. improved detection of heart attacks), changes in recording (e.g. recorded crime) or confounding (e.g. tuberculosis and immigration).
- Other data used in this report are derived from surveys (e.g. the Scottish Household Survey and the Scottish Health Survey) and are therefore subject to response and reporting biases. The lack of comparison groups (for example, groups not exposed to either the changing economic context or social security changes) make interpretation of the time trends, and of attributing causality, difficult.

The rapid review of the literature also had a number of important limitations:

- Bibliographic databases will not necessarily capture the full range of grey material. To overcome this a number of different approaches were used to try and identify as much of the relevant material as possible. The processes are, however, more ad hoc than systematic review processes – relying on some knowledge of the field and which organisations may be active in the areas of concern. It may mean that some material has been missed.
- While the appraisal process sought to identify sources of bias arising from the methods used to generate evidence, there may be some ‘commissioning bias’ where no evidence exists because no research has been commissioned on a topic area or population group.
- Because much of the grey literature identified is generated by advocacy groups, the range of groups identified may not mirror the range of groups (and subgroups) impacted but the patterning of advocacy groups. Many of the advocacy groups may also have a conflict of interest, with increased potential

for bias in the findings presented and emphasised. Some groups, who may not have a 'group' identity or a visible body advocating for/on their behalf, may be negatively impacted but remain less visible.

- Caution needed to be exercised in drawing conclusions from non-Scotland-specific evidence. A good example of this is the evidence on the bedroom tax/spare room subsidy, where the impact on Scotland is likely to have been partly mitigated by the different approach adopted compared with England through the use of Discretionary Housing Payments.

As such, the findings should be considered indicative, rather than definitive.

## 4.3 Pointers for the future

Much is unknown at this stage about both the future direction of the Scottish economy and the direction of social security policy. Both are still in flux.

Crucially, whether social security reform has a positive or negative impact on health and health inequalities in Scotland will depend on:

- whether labour market demand (in terms of jobs and hours) is sufficient in scale, and balanced geographically and occupationally, so that those looking for work have a reasonable chance of securing it
- whether the tax and benefit reforms by themselves act to increase or decrease socioeconomic disadvantage by income and protected characteristics
- the extent to which the reforms (and the package of support on offer) result in movement off working-age benefits and into work, especially for the most disadvantaged
- whether employment gained is sustainable, protects against poverty and is beneficial for workers' mental and physical health.

From the rapid review of the literature, the direct impact of welfare reforms from May 2010 to December 2014 was to widen and deepen inequality by income and between social groups, including by gender (although the impacts on men and women are different in nature) and with young adults, lone parents and people with health problems or disabilities most clearly at risk. A key question is the extent to which support from the social security system itself (e.g. through the Work Programme or Job Centre Plus), and the changing labour market, can mitigate, or perhaps even prevent or undo, these pressures. Detailed consideration of these aspects is outwith the scope of this report. However, there is evidence from elsewhere that certain groups (especially lone parents and those with health problems) are not well-served by current approaches by either Job Centre Plus or Work Programme providers.<sup>71,72</sup> It is also worrying that more than half of unemployed young adults are now outside the social security system entirely, and therefore not eligible for any of the official support offered to benefit claimants. Furthermore, a recent exploratory study concluded that there was 'little support for the view that welfare reform is having important and positive impacts on the labour market in Scotland',<sup>73</sup> raising concerns that losses to income and increased anxiety

and distress were not being compensated for with improved job opportunities by 2013.

The proposals announced in the UK Government's July 2015 budget represent an intensification of the reform programme carried out under the Coalition. Net changes to the tax and benefit system are regressive. Increases to the national minimum wage are likely to be offset by reductions in other benefits (especially tax credits) and other policy changes.<sup>74</sup> Examples include: the exclusion of under-25 year olds from increases in the minimum wage, cuts to tax credits for the third child (which will disadvantage low-income families with children, especially lone parents), and reducing the value of Employment and Support Allowance (increasing hardship to people with health conditions which prevent them from working). Given what is known about the association between income and health, and modelling of the effects on health of changes to the income distribution published by the Scottish Public Health Observatory,<sup>75</sup> these changes could potentially contribute to increased health inequalities.

## 4.4 Policy implications

While a number of indicators of health inequalities have remained stable or even narrowed over time, there remain many unjust, systematic differences in many health outcomes and economic determinants in Scotland. Efforts to reduce the human, social and financial cost of these inequalities should be maintained, including tackling the adverse consequences of changes to social security and developments in the labour market.

Economic recovery may also have the potential to 'pull in different directions' on population health. As incomes begin to rise, any potential beneficial impacts of recession on health will be reduced (which may include reduced alcohol-related harms and population-level obesity, which are both partly dependent on the affordability of unhealthy products, and reduced road traffic accidents). There are some indications that, for alcohol, this process may have started already, with a flattening off in the downward trend in sales of alcohol seen since 2009, along with increased sales of alcohol through off-trades and a rise in the number of alcohol-related deaths.<sup>76</sup> Further regulation of the alcohol and food markets could help protect against negative impacts as incomes rise.

The decline in income inequality during the economic downturn (primarily because of the large relative reductions in income for the highest income groups) has been associated with a decline in absolute and relative all-cause mortality inequalities among working-age adults. However, if the trends in income inequalities return to their pre-downturn trends then health inequalities are likely to start to increase again. It is important that policy ensures that the benefits of future economic growth are shared more equitably if health inequalities are to be reduced. This could include renewed attempts to boost both the quantity of work available in the Scottish labour market, and to improve the quality of employment, consistent with the recommendations made by the Marmot Review and elsewhere on creating Fair Employment and Good Work for All.<sup>31,77</sup> An economic recovery that increases the incomes of the poorest in this context may also check or reverse their rise in

overweight/obesity by allowing them to consume relatively more expensive, less calorie-dense foods.

Social security reform has yet to be fully implemented in Scotland (and the rest of the UK). The recent and planned changes to social security are likely to reduce the incomes of the poorest groups further and exacerbate health inequalities. Health would be protected by increasing the value of social security, reduced conditionality and reduced use of sanctions. In the meantime, mitigation through sensitive service responses for those placed in severe poverty are required.

For those affected by social security reform, the new powers proposed by the Smith Commission and the time lag before the full introduction of Universal Credit may provide opportunities for policies to mitigate the potential impact of social security reform on health inequalities. These could include: improving the quality and quantity and affordability of childcare; increasing the value of carer's allowance; ensuring that continuous reassessment for those on Personal Independence Payment only applies to people whose conditions are likely to improve;<sup>78</sup> and ensuring that young people with few skills and adults of all ages with health problems are given adequate support to prosper in the labour market.

Further research is required to continue to monitor the impact of changes to the social security system and economic trends on health and health inequalities, as well as to investigate the forms of economic development which are most conducive to improved health and reduced health inequalities. Linkage of individual-level HMRC and social security data to health data would allow a much more accurate and nuanced assessment of the impacts. The collection of this data would also improve the degree of confidence in any future studies of the impacts of changes to social security (including systematic reviews).

In the medium term, the findings suggest a continued need to monitor changes in mental health and obesity (both at population level and by income group) and more rigorous assessment of the impacts (positive and negative) of social security reform in Scotland, not just on health but on health inequalities, across the population and between different social groups. Further development and increased use of resources such as the Informing Investment to Reduce Health Inequalities (Triple-I) tool and of Health Inequalities Impact Assessment could be helpful here. The next update to this report will take place in 2017.



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