Health Inequalities in Scotland

Trends in the socio-economic determinants of health in Scotland

Chapter 6: Public services, welfare and democratic wellbeing

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6. Public services, welfare and democratic wellbeing

The quality and availability of public services and design of the social security system can affect health directly, in the case of health services, or indirectly via the way it influences broader socioeconomic determinants of health. The responsiveness of public services to people's needs, and the way in which these services are designed, can also influence peoples' perceptions about the influence they have over their circumstances, and hence their lives more generally. This chapter looks at the funding and design of public services and the welfare system, and trust in the political system more generally.

Key points

- In the ten years from 2010/11 to 2019/20, Scottish Government real terms spending on health increased by only one per cent per annum. Health spending had increased by almost 5% per annum in the decade prior to this. The spending increase of one per cent per annum is well below what would be required to maintain service quality in the face of growing need. By 2019/20, spending on health was £3bn - £4bn lower than it would have been had it grown at 3-4% per annum over the previous decade.
- The relatively slow increase in health spending after 2010 largely reflected the funding constraints faced by the Scottish Government as a result of the UK Government's austerity programme. But it also reflected Scottish Government decisions as to how to prioritise its budget. Spending on health in Scotland increased more slowly than in England in the decade after 2010.
- The decade after the financial crisis also witnessed significant change to the social security system, particularly working age social security. Most of these changes have eroded the value of the safety net provided by the UK welfare system, and at the same time have increased the requirements on claimants to meet eligibility criteria.
- The financial impact of the reforms on the lowest income households has been substantial. There is growing empirical evidence that some of the welfare reforms did increase the prevalence of mental health problems and anxiety.
- The UK Government's austerity programme – and its impacts on spending on healthcare, on social welfare, on investment in local services, and its contribution to the wider slowdown in earnings growth – was undoubtedly a major contributory factor to the slowdown in the improvement in mortality and life expectancy in Scotland and the UK after 2010, as well as more slowdown in health improvement more generally. The significant slowdown in health spending is arguably the channel through which austerity made its most contemporaneous contribution to the slowdown in mortality improvement. Changes to social security and various aspects of local services may have contributed to a rise in prevalence of mental health issues, but may have a long-term impact on health.
- Between 2006 and 2016, people in Scotland became increasingly less likely to trust the UK Government to take 'fair' decisions. This decline in trust was only partially offset by an increase in trust in the Scottish government to take fair decisions.
- Levels of dissatisfaction with public services have increased during the past decade, but only marginally. Dissatisfaction with public services has not obviously increased more rapidly in more deprived communities compared to less deprived communities.

Public services, democratic wellbeing, and health

Government policy plays a key role in influencing population health, both directly, and via influencing the socioeconomic determinants of health. Throughout this report we have drawn attention to some of the key ways in which policy has affected the socioeconomic determinants of health, whether that is through policies towards the minimum wage and wider labour market regulation and institutions, social security, education, and so on.

This chapter considers the impact of public policy more specifically. We start by looking at government spending on health. Whilst total spending on health is a somewhat blunt proxy for the quality and distribution of health services, there is undoubtedly a link between spending on health and the adequacy and quality of health outcomes, via the range and quality of treatments and the severity of waiting times. Health spending primarily includes spending on the NHS, but it also includes spending on a variety of programmes delivered by local authorities and some third sector providers, for example in relation to some programmes around mental health services, and alcohol and drugs policy. The chapter also examines trends in social care spending, the funding for which comes from both health and local government budgets.

The chapter then examines trends in local government spending by service area, as a proxy for the quality of various local services that might affect health indirectly in various ways – notably in terms of the provision of various community services that might be important for psychosocial health. It then considers changes to the UK welfare system, and the way that these may have influenced socioeconomic determinants of health such as financial security and loss of control over circumstances.

As well as the design of public services and the welfare system, democratic well-being may also influence health. One of the explanations as to why health is relatively worse in Glasgow than cities with similar levels of socioeconomic deprivation is because of a higher democratic deficit in Glasgow – which manifests as feelings of despondency, disempowerment, and lack of sense of control, which are recognised psychosocial risk factors with links to health outcomes (Walsh et al. 2016). This chapter therefore examines trends in trust in government as a proxy for the level of democratic deficit.

In this chapter we will talk about trends in perceptions of, and funding for, public services that are both reserved (notably social security) and devolved (health, and services delivered in large part by local government, including social care and education).

Real terms spending on health and social care stagnated between the financial crisis and the pandemic

From 1999/00 to 2009/10, UK government departmental spending increased robustly. The Scottish government's resource budget increased by an average of around 4.1% per annum. Scottish government spending on health per capita increased by around 4.7% per annum on average[1].

Following the financial crisis, the UK government embarked from 2010 onwards on a programme of 'austerity' to reduce the government's fiscal deficit from 10% of national income. We don't in this

[1] In this chapter, spending on 'health' is taken from HM Treasury statistics which define health spending in broadly comparable way to that set out in the UN's 'Classification of the Functions of Government (COFOG) classification.

report engage with the macroeconomic arguments for and against the austerity programme. There were of course choices that could have been made to reduce the fiscal deficit more slowly, or to rely more on tax increases rather than spending cuts to finance the fiscal consolidation. But rather than considering these issues, this chapter examines how the policy choices taken may have affected the socioeconomic determinants of population health.

The UK government's programme of fiscal consolidation relied heavily on cuts to public services spending. Spending on some areas of public services were 'protected' – notably including health care, international development and defence – but most other areas experienced real terms cuts between 2010 and 2018.

As a result, the Scottish government's budget – the annual change to which is determined by the UK government's spending decisions – stagnated for almost a decade. By 2016/17 the Scottish government's resource block grant was 6% lower in real terms than it had been in 2010/11, and it had only just returned to the 2010/11 level by 2019/20.

The Scottish government can allocate its resource budget across its devolved competencies as it sees fit. Faced with a declining or stagnating budget for the best part of a decade, the Scottish government made similar but not identical decisions about how to allocate its budget across spending areas as the UK government.

In particular, the Scottish government chose, like the UK government, to 'protect' health care funding. 'Protecting' health care spending in this sense means that spending on health care continued to increase in real terms, in contrast to other areas of public spending, which often experienced cuts.

But the fact that health care spending was 'protected' does not mean that health care spending increased sufficiently to meet needs. Between 1999/00 and 2009/10, spending increases by the Scottish government on health care had averaged almost 5% per annum in real terms. In the following decade, between 2010/11 and 2019/20, the real terms increase in health care spending in Scotland averaged just 1 per cent per annum. This rate of annual increase is a long way short of the 3-4% annual real terms increases that the Scottish government estimated would be required to maintain services in the face of demographic change and other cost pressures (Scottish Government, 2018).

So yes, health care spending was 'protected' relative to the spending of other departments, but it is very unlikely that the annual increases in health care spending post financial crisis were sufficient to meet 'need', i.e. to maintain service quality in the face of growing demand. The difference between a 1% annual growth in spending and a 3 or 4 per cent annual growth in spending may not sound huge, but over a ten-year period that accumulates to a large number. By 2019/20, health spending in Scotland was £3-£4bn lower than it would have been had it grown at 3-4% per annum from 2009/10.

Where the Scottish government's spending decisions differed from those of the UK government was in relation to how much health care spending was 'protected' relative to other areas of spending. The UK government chose to increase health care funding in England by relatively more than the Scottish government did in Scotland. The Scottish government chose to cut funding for non-health areas, including local government and justice, by relatively less than in England. It also allocated relatively more resources to higher education than the UK government did in England, reflecting its desire to maintain universal free higher education whilst the UK government significantly increased the level of tuition fees for English students (Gallagher, 2017).

The implication of these choices was that health care spending per capita grew less quickly in Scotland than it did in England for most of the decade following the financial crisis (Chart 6.1). Per capita spending on health care in Scotland was 10% higher than in in 2009/10, but by 2019 the gap had fallen to just 4%. Previous research has estimated that Scotland's relative spending needs for health – taking into account demographics, deprivation and sparsity – are at least around 10% higher than England's (Ball et al., 2015).

There have been efforts in Scotland and England in recent years to integrate health and social care services, with one aim of this being to reduce pressure on NHS services from people who could be being cared for in a social care setting. It is possible that slower growth in healthcare spending in Scotland post-2010 was offset by relatively faster growth in social care. However, there is little evidence that the slower growth of spending on health care in Scotland in the decade following the financial crisis was offset by relatively stronger spending growth on social care (Chart 6.2).

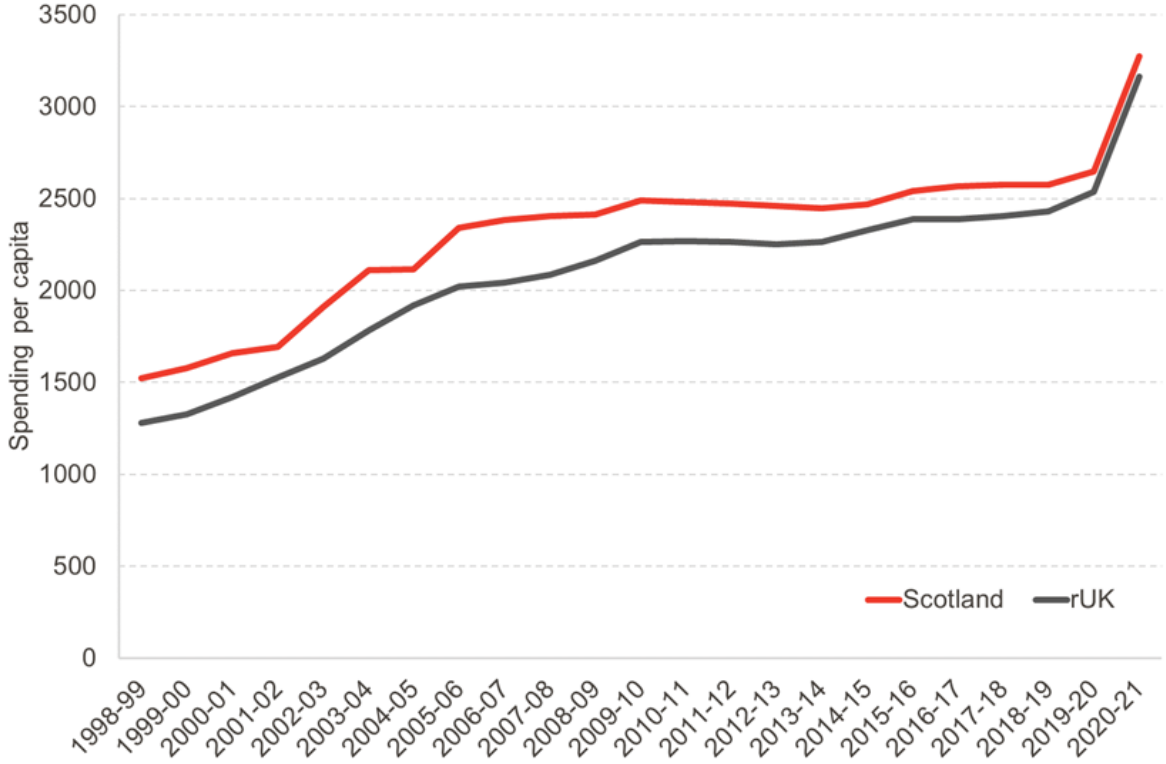
It is possible that, although total spending on health care in Scotland increased more slowly than in England after 2010, the health budget in Scotland could have been reallocated during this period in such a way as to mitigate health inequalities more explicitly. However we do not have any evidence on the extent to which this might have been the case.

It is clearly true that austerity was a political choice by the UK government, and it is also true that the way in which the UK government went about achieving fiscal consolidation – with an emphasis on departmental spending cuts – was also a political choice. But within the constraints of its own budget, the Scottish government has made choices too, and these have resulted in slower growth of per capita health care spending than observed in other parts of the UK[2].

[2] The relatively slower growth of Scottish health spending per capita is a choice that is implicitly bound up in the Scottish government's spending commitments, and the operation of the Barnett Formula which determines the Scottish block grant. The Barnett Formula allocates the Scottish budget a population share of spending increases in England. The Scottish government frequently commits to 'pass on' health related consequentials to the health budget in Scotland. But if Scotland starts with a higher level of spending per capita on health, a commitment to 'pass on' health consequentials will reduce the size of the relative per capia spending differential over time.

Chart 6.1: Real terms per capita spending on health stagnated after the financial crisis – and more so in Scotland than in rUK

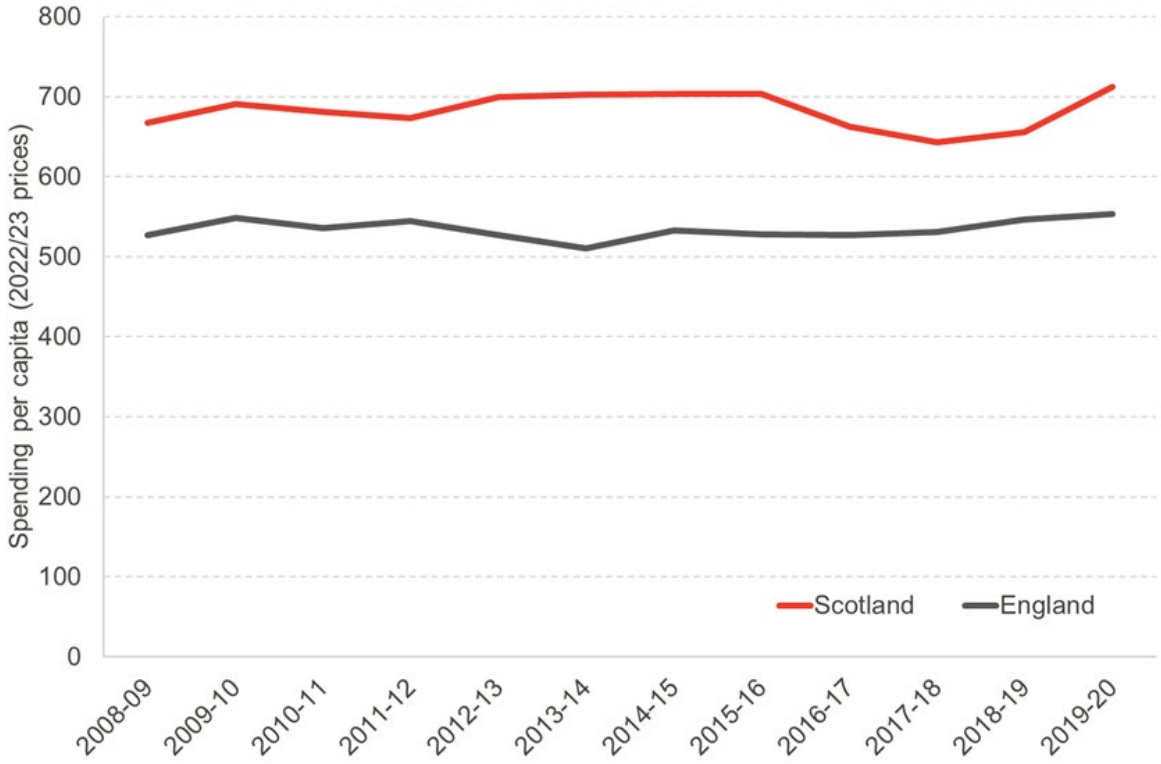
Per capita spending on health (£million), Scotland and rUK



Source: FAI analysis of Government Expenditure and Revenue Scotland (Scottish Government, 2021). Notes; chart shows resource spending, capital investment spending is excluded

Chart 6.2: Real terms per capita spending on social care has remained unchanged since the financial crisis

Per capita spending on social care, Scotland and rUK



Source: FAI analysis of Public Expenditure Statistical Analysis (PESA), HM Treasury (various years). Notes: social care spending is identified as 'Personal Social Services' spending in documentation, and amounted to £3.6bn in Scotland in 2019/20

Local government spending has been cut, but the cuts have not been distributed evenly across local government services

Whilst health care has been 'protected' from funding cuts during the last decade, at least relatively, the same cannot be said of local government. Between 2013/14 and 2017/18, the core local government revenue settlement declined by £750 million in real terms, which is equivalent to a 7% real terms reduction in its budget (Burn-Murdoch, 2018). Between 2017/18 and 2019/20 the local government settlement was broadly unchanged in real terms. It then increased substantially in 2020/21 in response to the pandemic, although much of this funding increase merely offset loss of revenues from non-domestic rates revenues, and fees and charges, and a large part of the remainder was passed on to businesses as grants – there was not therefore a substantial change in public services spending in 2020/21.

The real terms funding reductions for local government have resulted in a reduction in local government spending on public services, including schools. However, the cuts have not been passed on evenly (Chart 6.3). Spending on social work has remained unchanged in real terms, whilst cuts to local government schools spending in the early part of the austerity period have largely been reversed.

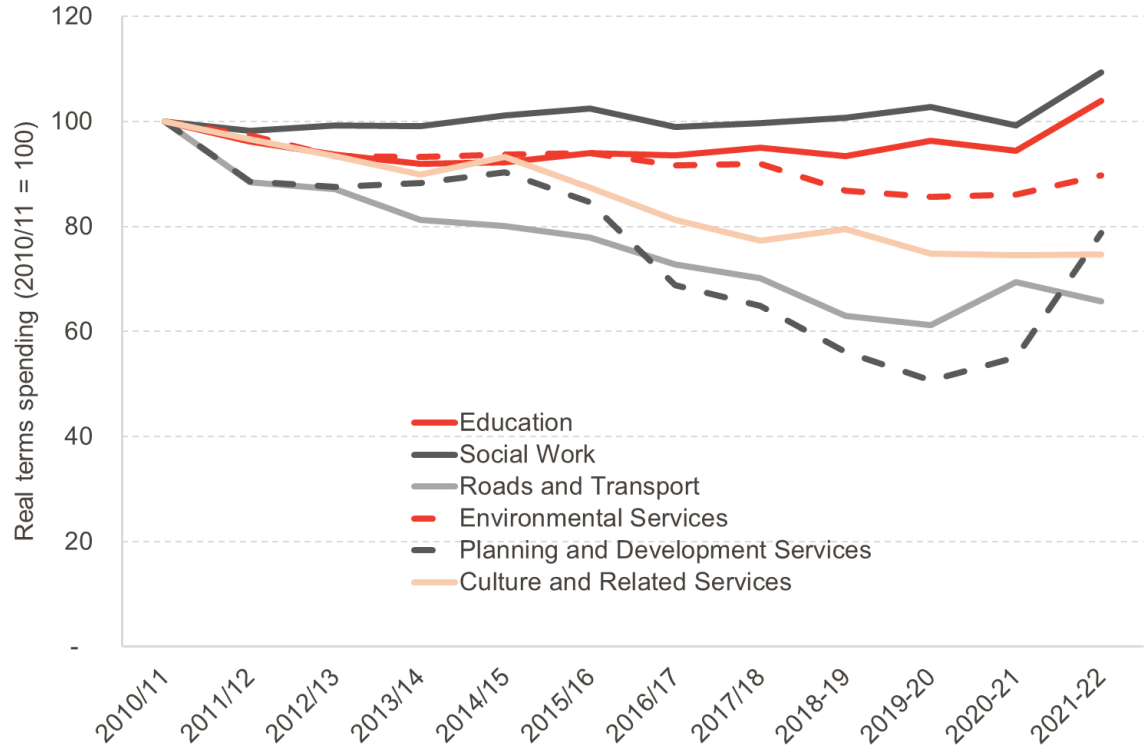
But if spending on these two significant areas has been largely protected in real terms, then it follows that spending on other service areas must have declined substantially. Indeed, spending on environmental services has declined by 10% in real terms since 2010/11, while spending on roads and transport, planning and economic development, and cultural services has declined by over 20%.

Local authorities have often reconfigured operations to try to ensure that frontline services are protected from cuts as much as possible. But funding cuts of 20% or more will inevitably result in some loss of service quality – which might include reduced opening or complete closure of community facilities for example, or reduced maintenance of public spaces.

These reductions in service quality might not impact health as directly or immediately as a decline in the quality of health services, but they may well affect health indirectly. Community facilities can play an important role in providing a base for activities that support psychosocial wellbeing in a variety of ways. Community-based services are also likely to be becoming increasingly important in providing support to people in need, given backlogs in NHS and social care support, until those services can respond. And education can affect health indirectly, as discussed in Chapter 4.

Chart 6.3: Real terms spending on cultural services, planning and development and environmental services has shrunk by over a fifth since 2010/11

Local government net spending by service area (2010/11 = 100)



Source: FAI analysis of Provisional Outturn and Budget Estimates, Scottish Government (various years)

UK welfare changes have increased stress and anxiety

As well as the changes to departmental spending, the decade after the financial crisis also witnessed significant change to the social security system, particularly working age social security. Some of these changes, but not necessarily all of them, were motivated and framed as part of the austerity agenda. The changes included:

- A 1% cap on increases in most working-age benefits and tax credits from April 2013 to 2015, and then a four-year freeze in most working age benefits from 2015 to 2019 – these resulted in significant real terms cuts in the value of most working age benefits over the period.
- An emphasis on increased welfare conditionality, and increased use of benefit sanctions. Use of sanctions increased particularly strongly from 2011 to 2013 but declined subsequently.
- Reduction of local housing allowance rates from the median to the 30th percentile of the Broad Rental Market Area, and subsequent real terms cuts
- The introduction of an arbitrary cap on the maximum benefit that a family can receive, followed by a reduction in that limit in 2016.
- The gradual replacement of six working age benefits into a new 'Universal Credit' from 2013. Under UC, some claimants are better off than they would have been under legacy benefits, but on average claimants are somewhat worse off. UC also involves longer lags between making a claim and receipt of first payment, and greater emphasis on 'activation' (job search requirements) than previous policies.
- The replacement of Disability Living Allowance with the Personal Independence Payment. PIP was introduced expressly with the aim of reducing the overall costs associated with disability and ill-health, in part by placing greater onus on claimants to prove their eligibility.

Many of these changes have either reduced the real terms value of the typical claim, or limited the eligibility criteria for a given benefit, thereby excluding some claimants from eligibility. Collectively, cuts to the generosity of the social security system since June 2010 amount to approximately £39 billion across the UK by 2019 (Crawford and Zarenko, 2019).

Both of these factors have weakened the average level of financial support provided to families across the UK. But the impact is relatively much greater on those families with the lowest incomes. Bourquin et al. (2020) show that the welfare reforms introduced between 2010 and 2019 will, once fully rolled out, reduce the incomes of the lowest 10% of UK households by around 10% (equivalent to £1,100 per year), compared to around 2% for the population as a whole. The nature of the changes introduced has tended to affect working age families with children particularly severely.

To the extent that these policies reduce the financial support available to low-income households, heighten the risk of food insecurity, and threaten the adequacy of income, we might expect them to contribute to worsening health amongst that group. Increased stress and anxiety might also result from the greater onus on claimants to undertake 'activation' activities, and the greater prospect of being sanctioned if their activities are deemed insufficient. The changes might also increase stress and anxiety amongst those not currently eligible for the benefits, if they realise that the value of the safety net has deteriorated.

Indeed, there is growing empirical evidence that some of the welfare reforms did increase the prevalence of mental health problems and anxiety. For example, Reeves et al. (2020) find that between 2015 and 2018, the prevalence of depression or anxiety increased more amongst those at risk of having their benefit capped than it did amongst those who were not at risk of being capped. Wickham et al. (2020), by exploiting the staged rollout of UC in different parts of the UK, show that

the introduction of Universal Credit was associated with an increase in psychological distress. Brewer et al. (2022) use a similar methodology to examine the effect on mental health of becoming unemployed under UC compared to the legacy welfare system. They find evidence of heterogenous effects by group – for lone parents and single adults, becoming unemployed under UC is worse for mental health than becoming unemployed under the legacy system. For couples with or without children, the effect of becoming unemployed on mental health is no different under UC than the legacy system (since some improvement in administrative difficulty in claiming offsets somewhat lower income).

A number of austerity-related social security policies that were introduced by the UK government were largely mitigated in Scotland by the Scottish government. The policies that were mitigated included:

- The so-called 'bedroom tax', which reduces the level of Housing Benefit for those deemed to have more bedrooms in their property than is strictly necessary given the size of their household.
- Reductions to the level of Council Tax Reduction that were applied in 2013.

The mitigation within Scotland of some of the UK welfare reforms since 2010 is likely to have been significant for some of the households who were directly affected by the policies mitigated. Overall however, it is probably unrealistic to expect that the Scotland-specific mitigations would have an observable impact on Scottish health at population level. This is because the mitigations were fairly marginal in the context of the broader changes that took place. The Scottish government spends around £50m per year mitigating the impacts of the 'bedroom tax', but estimates that UK government welfare cuts amount to around £3.7bn annually in Scotland.

Austerity contributed to the slowdown in health improvement

In Scotland, as in the UK as a whole, the almost continual improvement in mortality rate following the second world war stalled in around 2012. Mortality rates affect calculations of life expectancy. The slowdown in mortality improvement was such that, by 2018, life expectancy was 1.3 years lower than it would have been had the previous trends continued. The slowdown in mortality improvement has been more marked for people living in the most deprived neighbourhoods ranked by SIMD than those in less deprived neighbourhoods (Miall et al. 2022).

In 2012 there was a similar – but even more marked – stalling in the long-run improvement in healthy life expectancy (Miall et al. 2022).

There has been a wide debate about the potential causes of this stagnation in mortality improvement. The timing of the stagnation in mortality improvement broadly coincides with the period of 'austerity'. Inevitably, this has led many people to argue that 'austerity' was in some way a material factor behind the stagnation in mortality improvement.

Indeed, it seems almost undeniable that austerity will have played a significant and substantial contributory role. Whilst correlation does not prove causation, the coincidence of such an unprecedented stagnation in mortality improvement with an equally unprecedented slowdown or reduction in public services spending is difficult to explain through alternative mechanisms.

McCartney et al. (2022) investigate a number of explanations for the slowdown in mortality improvement since 2012, and conclude that it cannot be materially accounted for by factors – such

as rising deaths from drugs or dementia, an increased prevalence of weather extremes, or a slowdown in improvement from cardio-vascular deaths – that could feasibly have been dissociated from austerity. They conclude that there is 'good evidence that austerity has contributed to the stalled mortality trends'.

It is more difficult to identify specifically which aspects of 'austerity' contributed to the slowdown in mortality improvement, and hence life expectancy[3]. The decade-long period in which real terms health spending increased much more slowly than health spending 'needs' were increasing could plausibly have had a relatively contemporaneous impact on mortality. The fact that the slowdown in mortality improvement is observed across all demographic groups is also suggestive of the idea that the quality of health services may be material to the trends.

Changes to social security spending and conditionality have undoubtedly had negative impacts on mental health, but are arguably less likely to have had a material affect on mortality - yet. The changes to social security have significant impacts on the individuals affected. They have also been linked to suicide in some cases. However, there is a case for saying that, whilst such changes may have contributed to rising prevalence of mental health problems, they seem less likely to have had a contemporaneous impact on the slowing of mortality improvement to date. But they are nonetheless likely to be contributing to a number of other morbidity issues, and may, by reducing the resilience of people to manage changes in their circumstances, be storing up further problems for the future.

This is not to say that austerity has been the only factor that led to the slowdown in mortality improvement, and wider health improvement, post-2010. As we showed in chapters 2 and 3, the post-2010 period has also seen an unprecedented stagnation in gross (pre-tax) real earnings, and as a result in household income. Its difficult to disentangle the role of this more general slowdown in income on health from the effects of 'austerity' on household income. Not least, this is because 'austerity' is likely to be a contributory factor itself in the slowdown in earnings (via the impact of austerity on aggregate demand in the economy). But austerity is probably not the only factor that contributed to the unprecedented earnings slowdown post 2010 (the start of the slowdown in earnings probably dates to around 2007).

The conclusion that austerity played an important and significant role in causing the slowdown in mortality improvement during the past decade seems undeniable. The immediate channel through which this happened is arguably through constraints on healthcare services. Other policy changes brought in during the austerity period, including changes to social security, and cuts to local government services to vulnerable groups, are also likely to have had an impact on population health more generally, including through contributing to an increase in prevalence of mental health issues.

People in Scotland have become less likely to trust the UK government to make fair decisions

Across countries, poor health and decreased trust in political systems are closely correlated, but it can be difficult to ascertain which one causes the other.

[3] Life expectancy is calculated as a function of observed mortality rates, and expected changes in mortality rates in future.

When people feel powerless to influence policy and decisions that affect them, this can have negative consequences for health. Carnegie UK has stressed the importance of 'democratic wellbeing' as a means both to greater social and economic wellbeing and an end in itself, impacting directly on wellbeing (Heydecker et al. 2022). Democratic wellbeing refers to the extent to which people feel they have a voice in decisions that affect them. Democratic well-being is the sense of satisfaction that individuals and groups get from having the ability to participate and trust in political and governmental structures (Orviska, Caplanova and Hudson, 2014). Engagement and trust are not necessarily the same thing. As Heydecker et al. note, 'in order for people to feel positive about participating in democratic processes and decision making, it is essential to have public trust in government'.

This concept of 'democratic wellbeing' is in a sense the opposite of the concept of a 'democratic deficit'. It has been argued that a 'democratic deficit' was one of the important factors in explaining excess mortality in Glasgow compared to similar cities in England, and more generally in Scotland compared to England, over and above what would be expected given higher levels of socioeconomic deprivation in Glasgow and Scotland. (Walsh et al. 2016).

The broad hypothesis of Walsh et al. is that Glasgow (and Scotland more generally) was made more vulnerable to the socioeconomic and political determinants of health over a prolonged period through the way that various socioeconomic policies were implemented. These included the 'socially selective' New Town programme which aimed at relocating business and families to new towns and other areas outside the city, and the nature and scale of urban change in Glasgow in the post-war period, including lower investment in public housing, and a greater emphasis on high-rise developments. The so-called 'democratic deficit' of that period, which is characterised by Walsh et al. as 'feelings of despondency, disempowerment, and lack of sense of control (recognised 'psychosocial' risk factors with links to adverse health outcomes)' is hypothesised to have accentuated the negative health impacts of the policies implemented in Glasgow.

There are a number of ways we might think of trying to proxy democratic wellbeing (or its inverse, democratic deficit). We focus here on responses to questions in the Scottish Social Attitudes Survey which ask respondents: 'to what extent do you trust the government to make fair decisions?' The question has been asked in most years since 2006 and is asked specifically in relation to both the UK government and the Scottish government.

The most striking finding from this data is that the proportion of people in Scotland who trust the UK government to make fair decisions 'not very much or not at all' has increased fairly substantially between 2006 and 2016 (Chart 6.4). In other words, distrust of the UK government has risen.

In contrast there is evidence that the proportion of people in Scotland who trust the Scottish government to make fair decisions has increased over the period, although there is quite a lot of variation from year to year.

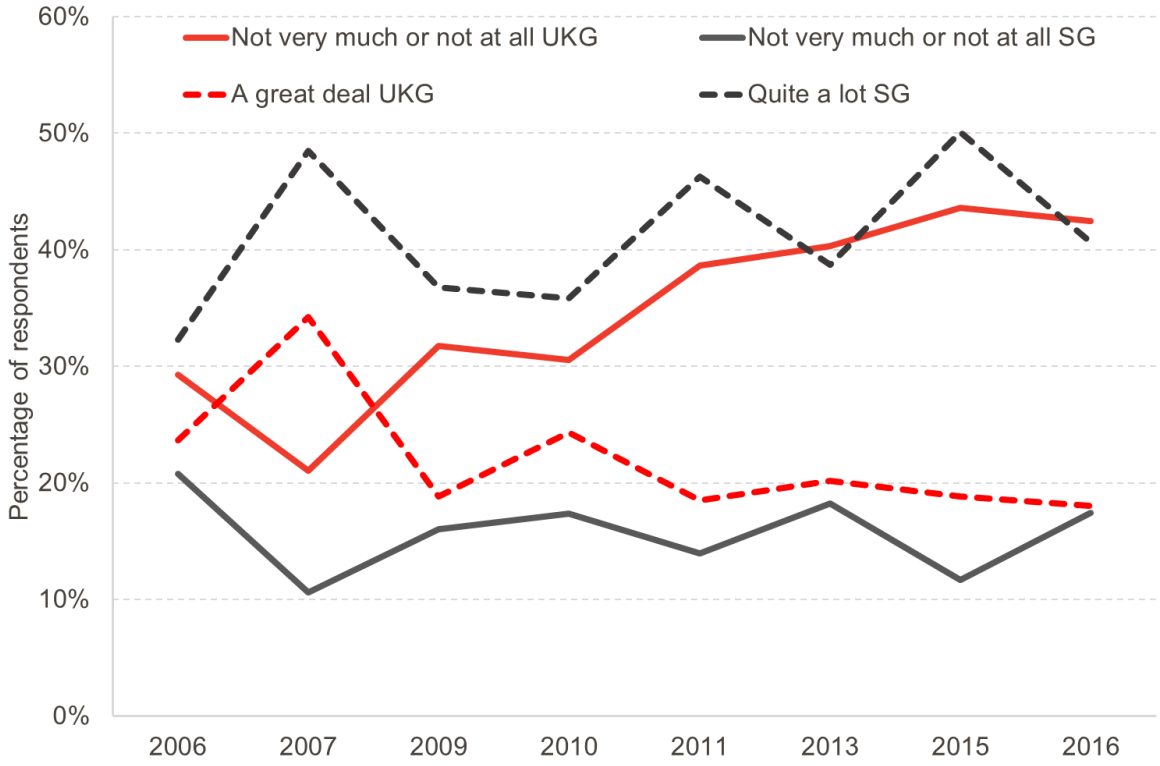
It could be argued that a more relevant indicator is the extent to which individuals trust neither government (to abstract from issues about changing political sentiments). However, having looked at this, it is impossible to conclude that there is any obvious trend over time in the proportion of the population who do not trust either government to make fair decisions – which averages around 12% of the population and varies between 8% and 16% in different years. Incidentally, those who do not trust either government to make fair decisions are twice as likely to self-report their health as bad (12.4% v. 6.8%) or very band (3.1% v. 1.5%) compared to those who trust at least one government.

We can also look below the surface to see how trust in the two governments to make fair decisions varies by quintile of neighbourhood deprivation. Chart 6.5 shows that levels of distrust in the two governments are similar across quintile of neighbourhood deprivation.

Further analysis of public attitudes towards government and policy institutions will be published as part of the wider Health Foundation project of which this report is part.

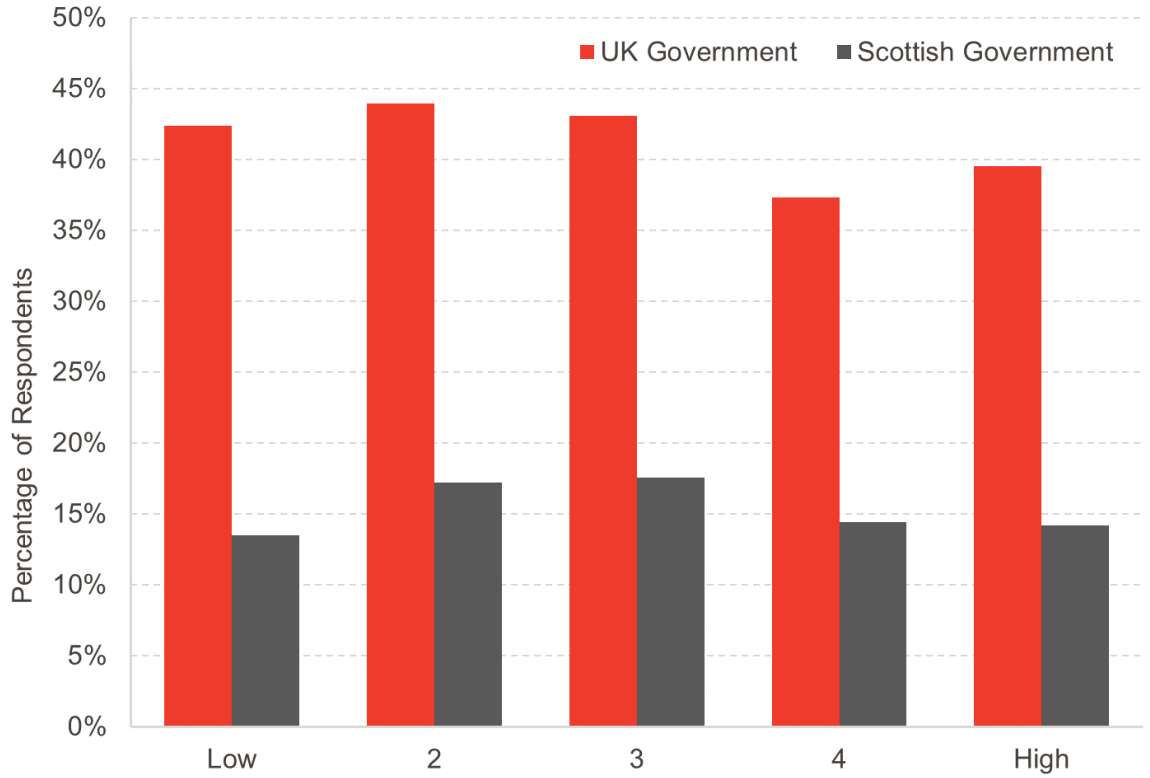
Chart 6.4: The proportion of people in Scotland who do not trust the UK government to make fair decisions has increased

Percentage of respondents who gave particular responses to the questions, 'do you trust the UK government/ Scottish government to make fair decisions?'



Source: FAI analysis of Scottish Social Attitudes Survey. Unweighted N = 11,032

Chart 6.5: Levels of distrust in the two governments are similar across deprivation quintile
Percentage of respondents who 'don't trust' or 'don't trust at all' the governments to make fair decisions, by quintile of neighbourhood deprivation



Source: FAI analysis of Scottish Social Attitudes Survey. N = 5,118. Notes: responses averaged across 2011-2016 period

Dissatisfaction with public services has increased slightly since the austerity period

Levels of dissatisfaction with public services might proxy their quality and potentially their impacts on health via psychosocial channels.

Chart 6.6 shows that dissatisfaction with local health services declined in the years leading up 2011, but that this improvement reversed during the subsequent austerity years. There is little evidence that levels of dissatisfaction with public services are fundamentally higher or lower for those in less deprived relative to more deprived areas.

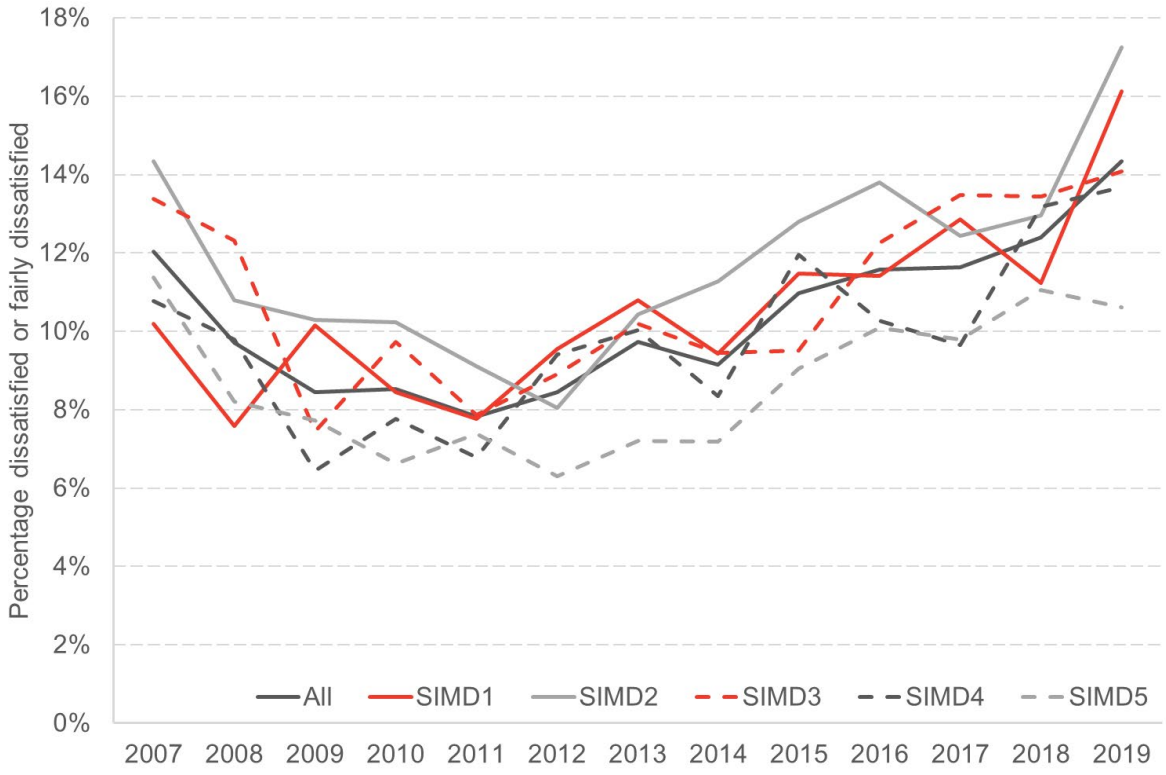
In contrast, the proportion of respondents expressing dissatisfaction with a range of statements about their local authority, whilst higher than those expressing dissatisfaction with health services, has not obviously increased during the decade of austerity (Chart 6.7). Our analysis shows that the trend is similar across the five quintiles of neighbourhood deprivation. Dissatisfaction is generally somewhat higher amongst the more deprived neighbourhoods compared to the least deprived neighbourhoods, but trends over time are similar.

Forthcoming analysis by the Scottish Government's Expert Advisory Group on Population and Migration shows that satisfaction with public services if often higher in remote rural parts of

Scotland than in other areas, but often tends to be slightly lower in more accessible rural areas (Expert Advisory Group on Population and Migration, forthcoming).

Chart 6.6: Dissatisfaction with local health services has increased since the austerity period

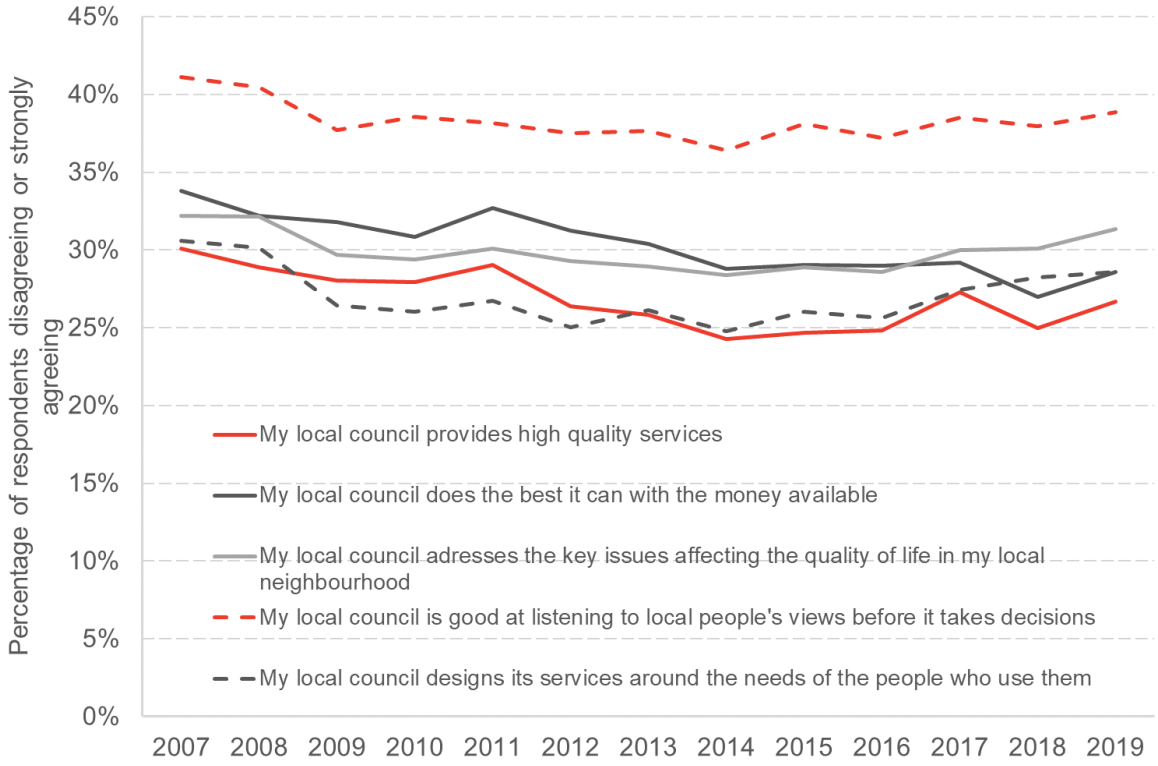
Percentage of respondents dissatisfied or fairly dissatisfied with local health services



Source: FAI analysis of Scottish Household Survey. N = 125,687

Chart 6.7: Dissatisfaction with local authority services has not significantly changed during the austerity decade

Percentage of respondents dissatisfied or fairly dissatisfied with a range of statements about their local authority



Source: FAI analysis of Scottish Household Survey. N = 125,687

Conclusions

The quality and availability of public services and design of the social security system can affect health directly, in the case of health services, or indirectly via the way it influences broader socioeconomic determinants of health.

The period since 1999 can be thought of in three distinct phases. During the first decade, public services spending grew relatively rapidly in real terms, and spending on social security increased. The austerity period from 2010 until the onset of the pandemic has seen huge changes in the funding of public services and in the design and operation of the social security system in the UK. The pandemic itself instigated large temporary spending changes which are discussed further in Chapter 8.

Healthcare spending increased far more slowly in the decade after 2010 than it did during the previous decade. The pace of the funding increase since 2010 has almost certainly not kept up with the increases that would have been necessary to maintain the quality of service delivery, taking into account demographic changes and the costs of health technologies.

Many other areas of public spending have faced real terms cuts. Cuts to local authority funding have resulted in substantial reductions in the funding of community and cultural facilities and discretionary economic development services.

There have also been huge changes in the social security system. In combination these have had the effect of significantly weakening the social safety net, and exposing claimants to greater levels of financial insecurity.

The spending cuts implemented during the austerity period coincide with an unprecedented stagnation in the improvement in mortality rates. Whilst austerity is unlikely to be the only factor determining the slowdown in mortality improvement, it seems difficult to deny that austerity was a major – indeed the most significant single – contributory factor.

The dramatic slowdown in the growth of health spending may be the most direct way that austerity contributed to the contemporaneous stagnation in mortality improvement. More generally, the effects of social security cuts on financial wellbeing and mental health, the impact of cuts to local government services to vulnerable groups, and the more general effects of austerity on earnings growth, are likely to have contributed to a more general stagnation in health improvement, including a rise in the prevalaence of mental health issues. To the extent that socioeconomic factors influence health with a lag, these more general factors may continue to weigh on health improvements in coming years.

Perhaps surprisingly, there is limited evidence of a rise in levels of dissatisfaction with public services over the past decade. Levels of trust in government have declined slightly, with a large decline in trust in the UK government partially offset by a growth in trust in the Scottish government.

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