Health and Wellbeing Inequalities in Seaside Resort Towns: A Window on Policy Interventions in an Unequal Society

Peter Lloyd and Michael Blakemore

November 2021[1]

Disclaimer: The views in this paper are personal views of the authors and are not representative of any organisations to which they are affiliated.

Preface

Before the Covid-19 pandemic, there was strong interest from Parliament and the Chief Medical Officer (CMO) on the health and wellbeing problems of what have been variously called Seaside Towns or Coastal Communities. There was said to be little research on them and no strategy that tried to deal with their specific issues. If things were bad for them in 2007 and in 2017 when these major government reports were written, they are undoubtedly very much worse now. Covid-19 attacked the nation's pockets of multiple deprivation and retirement locations hard wherever they were, and places in coastal settings took their excess share of the infections, hospitalisations and deaths (not least among the care homes).

This paper makes no attempt to add empirical detail on coastal places (the reports do that) but tries to relate their experiences to deeper issues in a country that has allowed a massive growth in inequality over the last four decades. The seaside town story allows us to explore what can emerge at the social and geographical "end of the pipeline" when inequality is just accepted and when a decade of austerity hits policies for health, education, housing, welfare support, and, in particular, social care in places with a long history of deprivation.

From the "social determinants of health" perspective that the CMO's report adopts, the causal processes involved in producing and extending multiple deprivation are revealed as complex, closely inter-connected and contextually specific. Setting this against the standard suite of local economic development and regeneration policies (and now "levelling up"); job creation and physical regeneration seem to be all too readily accepted as the means to make people better off and thus healthier. While local investment and job creation has a key place, hoping for economic trickle down is far from sufficient to stop already disadvantaged people sliding further into precarious lives.

It was Covid-19 that showed us that only by seeing what was going on at the micro-local scale, could we grasp how co-connected the "social determinants" are on the ground. In coastal places, the often inter-generational roots of multiple deprivation (health, education, early years experiences, housing and so on) that Marmot emphasised 20 years ago are all too easy to see. The paper that follows uses the seaside resort towns as a case example to explore how policy needs a "whole system" and locally more granular view.

[1] Please cite as: Peter Lloyd and Michael Blakemore (2021) *Health and Wellbeing Inequalities in Seaside Resort Towns: Some Post-Covid Lessons for Policy Design*, https://www.peter-lloyd.co.uk/papers-and-blogs/

Coastal Places and their Problems: Deep roots and "structural factors"

As the newly appointed Secretary of State for health indicated in an interview with Nick Robinson (BBC, 1st September), one of his great concerns is health inequalities. After a visit to Blackpool, he indicated that such places are very much part of his agenda for improvement and stated that for these places there was a century long history of *health disadvantage* which revealed what he called serious underlying *"structural factors*".

This was a welcome declaration, and this paper reviews some of those "structural conditions" that he was talking about. It is to be hoped, however, that the Secretary of State is looking in his own political backyard for some of the more immediate causes. A first step in this direction would be to acknowledge just how serious the general level of inequality has become - not just in particular places but across the nation as a whole. Nevertheless, looking for "structural" roots, is still a good place to start, not least because this will make it clear just how far we have to go under the present macro-policy regime, and so see what might really be needed to make a difference.

The context chosen here is the set of what we will go on to call *Seaside Resort Towns (SSRTs).* Blackpool would be among the best known of them. This forms a subset within a wider group variously called *Seaside Towns, Coastal Towns* and *Coastal Communities*. This collection of places has been attracting academic attention over many years (Beatty & Fothergill, 2003)(Beatty & Fothergill, 2004), Farr, 2017).

A House of Commons Report published in 2007[2] under the aegis of the then Department of Housing and Local Government declared (p.4) that:

> *"There is a need for Government departments to develop an understanding of the situation of coastal towns and work together to address the broad range of common challenges that these towns face".*

A later cycle of government attention was focused on the issue of health inequalities. This emerged from the House of Lords in 2017[3], and later from the Annual Report of The Chief Medical Officer in 2021[4], who declared that:

> *"Coastal communities[5] have been long overlooked with limited research on their health and wellbeing. The focus has tended towards inner city or rural areas with too little attention given to the nation's periphery".*

The input by the Chief Medical Officer is particularly welcome. His report is comprehensive and important. The salient point is that, once health and its social determinants come into the frame, it is no longer possible to ignore the intricate connections involved in producing multiple deprivation – whether in coastal settings or elsewhere[6]. Housing, poverty, indebtedness, the limitations of the welfare system, and an inability the care system to cope with extreme levels of health inequality, all play a role in a

[2] https://publications.parliament.uk/pa/cm200607/cmselect/cmcomloc/351/6070402.htm
[3] http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-
[4] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities
[5] The CMO report declares that; *"There is no nationally agreed definition or consensus on what constitutes a 'coastal community' and goes on to state that "The term 'coastal community' will therefore be used throughout this report to encompass any settlement along the coast (including village, town and city)". No further attempt at definition is made.*
[6] For a recent take on this see: https://www.ippr.org/files/2021-10/1634571731_disease-of-disparity-oct-21.pdf

complex, connected web of causation that plays out locally and in context[7].

The insertion of health and its social determinants should make it possible to shift the whole discourse on the nation's deprived (or "left behind") places (Rodríguez-Pose, 2018). Past remedies to the challenges of the most deprived coastal towns (and other "left behind" places) have tended to stick closely to the policy script of economic development and regeneration, with funds allocated under various UK and EU programmes (Pike, Rodríguez-Pose, & Tomaney, 2007) .

The standard policy response tends to have been: Invest in the physical infrastructure, improve skills, make the local economy more competitive, create more jobs, and then depend on a trickle down effect to overcome deprivation. In coastal settings, the particular sensitivity of the physical environment tended to add a conservation dimension[8].

Sitting on the outer edges of the economy and society to which they belong, the SSRTs act as a "screen" onto which economic, social and political ills are projected in particularly sharp relief. There is, however, nothing simple about the problems they face or the causalities underlying them and policies to address them needed to have the "requisite variety" to cope with the complexity of the processes producing social deprivation[9].

What these coastal places can do more broadly, is provide an experimental environment to "*join the dots"* surrounding these complex interactions and try, in the Secretary of State's words, to *"understand the broad range of challenges*". The CMO's report opens the door to this and the experience of Covid-19 has made it clear that more needs to be known about local places, and how better to align the system of policy management towards the adoption of a "whole system" perspective. A decentralised view is needed – one that works across and between disciplinary and departmental boundaries and is inclusive of the views of the local population.

Tackling the problems in discrete silos with distributed central funding without an appreciation of the wider contextual reality of the local, has clearly fallen short. Of course, we await the proposed new thrust of local and integrated policy-making in the sphere of health and social care[10] This is considered later in the paper before we go on at the end to offer own suggestion in the form of a more comprehensive Pact-based approach.

Seaside Resort Towns: Simple labels, decontextualised policies

Let us be clear at the start about the geographical label used here. From the literature and government papers and policies, the labels used are, variously, Seaside Towns, Coastal Towns and Coastal Communities. Looking across the categories, our own conceptual framework for analysis is the *Seaside Resort Town*.. This sets out the geography (seaside), the dominant economic context (resort) and the

[7] It was of course Michael Marmot *Fair Society, Healthy Lives* was published (2010) and ("Health Equity in England: The Marmot Review 10 Years On - The Health Foundation," 2020) who alerted us the issue of health inequalities. This is defined (NHS) as follows: *Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age.*

[8] For coastal environments specifically, some £1.46 million was provided to 146 teams around the British Coast. Later, a Coastal Revival Fund of over £7.5 millions was made available to "*support projects in coastal areas to help kick-start regeneration of 'at risk' coastal heritage that has the potential to create opportunities for new economic uses.* https://www.gov.uk/government/collections/coastal-communities

[9] Informally defined as; *"in order to deal properly with the diversity of problems the world throws at you, you need to have a repertoire of responses which is (at least) as nuanced as the problems you face".*

[10] https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained

position in the urban hierarchy (town). It represents a defined subset within the wider groupings but one with its own internal variety. We can learn a lot more in general terms from examining locations where the contrasts are so sharply etched.

Looking at past policy frameworks for the SSRTs from the outside, their problems can, at first sight, seem disarmingly straightforward. Their economies tend to be mono-sectoral, being dominantly tourism and leisure based. The population tends to have a binary bias toward the younger socially disadvantaged and the older-aged. Their workforce is dominantly attached to low wage and low skill occupations. Their economies are highly sensitive to cycles and seasons, and they tend to have a "below-par" physical infrastructure and living environment.

Jump from there to policy and once again things can look misleadingly simple - diversify the economy, educate and upskill young people and workers, improve the infrastructure and environment, support the old better and encourage healthier lifestyles. Enterprise zones, Free Ports, Special Programmes and Challenge Funds have emerged as the contemporary policy fixes. Get the economy and infrastructure right and market forces will start a positive trickle-down process to help workers and families improve their lives and health.

People who know SSRTs, and especially those who live and work in them, would rightly be surprised at this over-simplified caricature of what they are like, and what is needed to fix their problems. It is a picture that all too easily feeds into the negative symbolism of how these places are seen by the wider population[11]. As the CMO (Whitty, 2021) makes clear in his Coastal Communities report, shifting the lens down to a more detailed level reveals *huge variety* both between these places and within them. Each has its own history, geography and social and cultural context. They are not all poor and deprived.

For example, behind the Blackpool "Golden Mile" or its equivalent in other places, there tends to be a town that has all the attributes of any place of equivalent size with its own distinctive local economy - much of it not necessarily connected in any immediately obvious way to the holiday resort role. Broad scale aggregated data at county or sub-region level tends to make this hard to see, and the extreme Index of Multiple Deprivation (IMD) data for certain local areas (electoral wards) means that the focus tends to be pulled toward a "struggling place with extreme health and wellbeing inequality".

The SSRTs do, of course, tend to display higher than average levels of health and wellbeing inequality. But this needs to be set in the *wider local context*. Each SSRT has its strengths a well as weaknesses. The narrow view tends to emphasise the second over the first. Setting out to fix a "century-long" problem by improving the economy and waiting for trickle-down, while targeting actions on the most extreme situations, has not shifted the dial of inequality in health and wellbeing.

We are coming to the realisation, emerging gradually from Covid-19, that the causal processes that produce negative outcomes are only understandable by recognising their *complexity and essential*

[11] https://www.independent.co.uk/health_and_wellbeing/
https://www.theguardian.com/society/2021/jul/21/english-coastal-towns-have-some-of-countrys-worst-health-report-says
https://www.bbc.co.uk/news/uk-57908387
https://www.theguardian.com/inequality/2017/sep/04/seaside-towns-among-most-deprived-communities-in-uk
https://www.theguardian.com/society/2021/jul/21/english-coastal-towns-have-some-of-countrys-worst-health-report-says
https://news.sky.com/story/decay-and-decline-seaside-towns-desperate-for-investment-11778384
https://unherd.com/2019/04/why-lifes-no-beach-by-the-seaside/
https://www.ft.com/content/b5317c64-59ee-11e9-9dde-7aedca0a081a
https://www.voice.wales/a-trip-to-rhyl-how-the-pandemic-hit-wales-most-vulnerable-seaside-town/
https://www.independent.co.uk/news/uk/home-news/coronavirus-uk-seaside-coast-skegness-blackpool-clacton-scarborough-thanet-a9688026.html

connectedness. The social determinants of health emerge from the broad range of social and economic circumstances confronting people in their lives[12] *Context* is critical and acting together in full knowledge of the overall local situation, and engaging local people, is essential when designing policy interventions.

A place-defining historical legacy of booms, busts and reinvention

The "century-long history" cannot be ignored when imagining solutions - not least because legacy goes deep into contemporary circumstances. There are, for example, some important things to grasp to help us understand how most SSRTs have come to take their modern form. The historical legacy powerfully impacted their physical shape and key elements in their inter-generational socio-economic profile.

Coastal towns played a distinctive economic role over time by virtue of the role they played in the "spatial division of labour" (Massey, 1995)[13]. It was the special properties of the land-sea interface that proved to be the key attraction to capital investment - whether for ports, fishing, shipbuilding or later for leisure pursuits. In response, cycles of investment passed through coastal towns seeking out profitable return. Some lasted, but others were short-lived. For the seaside resort, it was the beach with its health and recreational connotations that presented the source for value extraction. This had to wait until the mid-19th Century, however, to be realisable.

A recurring point is that the form that resort development took was highly contingent on *things happening elsewhere in the economy and in society.* Two significant forces worked together to shape them (abstracting from their elite early beginnings[14]). One was the arrival of the passenger railways. But no less important was the political struggle for factory workers pay and time off. It was the combination of *better wages, more leisure time and mass access through railway travel* that unlocked the opportunity for the holiday resorts to emerge and that profoundly shaped the form they took.

Above all, and still highly significant to the overall story of how they evolved, it was a *particular socio-economic group* that attached themselves to the emerging Seaside Resort Towns, both as visiting consumers and as workers. SSRTs were essentially a mass working class phenomenon (Farr, 2017). In "structural" terms, a look at the shifting fortunes of this segment of British society helps to provide a strong clue as to what these places look like today. Being geographically on the land margins and socially attached to a particular class provides a strong key to understanding how the seaside resort story played out.

Important in shaping the physical fabric of the SSRTs, was that the investment waves required cost-efficient (i.e. cheap) and "appropriate" accommodation for them to thrive for their cash-constrained pleasure seekers. The beach and the shoreline, most critically, provided a prime space for recreation free of charge to all[15]. Over time, booms, busts and reinventions saw the buildings and basic infrastructure installed that still shapes the urban form - framed within the relatively unpretentious preferences of a dominant socio-economic consumer group.

Most places that turned into holiday resorts were thinly populated beforehand and needed to draw in

[12] https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health
[13] The work of Doreen Massey is particularly illuminating for SSRTs with her idea of geographical "waves of investment" shaping the emergence of places over time.
[14] From the popularisation of Weymouth by King George III (14 visits to the seaside to seek relief from chronic illness) at the turn of the 17th century to the present day, the beach resort has figured in the national search for better health.
[15] Their crown land property makes them unique as UK travellers overseas have come to understand as they pay for access in other countries they visit as tourists.

largely unskilled workers from outside. With the seasonality of employment, a short-term transient workforce was built in as part of the normal labour market. Again, as a feature of significance for the SSRTs distinctiveness, this tended to work against significant attachment by the workers to the local residential community. Social forms like spatial ones have historical antecedents.

Like the towns of the Gold Rush era, things tended to happen quickly in the early days and with a tendency to outrun regulation. Low barriers to workforce entry, seasonality, low social attachment and a cash-in-hand wages system was to be readily associated with sub-cultures revolving around drug and substance abuse and gambling. All these background conditions in combination served inter-generationally to influence the evolving social fabric of the SSRTs.

With time, the traditional seaside marketing messages of "ozone" and healthy living shifted in response to the consumer preferences of new generations. Investment and promotion moved toward the "night economy" and the promotion of the "spectacular experience". The short visit and the search for more exotic entertainment was an obvious response to the major crisis that followed the arrival of the cheap Mediterranean package holiday. With the decline of the traditional seaside family holiday, the resort pitch moved more toward younger people.

As a product of these changes, small hotels and boarding houses began their decline. This had the effect of opening the door to re-purposing the property into low rent and benefit-subsidised housing stock. Significantly for what today's detailed LSOA maps of multiply-deprived households show, Houses in Multiple Occupation (HMOs) tended to colonise settings adjacent to the old commercial core and behind the prime real estate of the beach strip.

The new occupiers of the HMOs tended to be people struggling with precarious lives, coming both from within the existing population and those arriving from outside seeking cheap accommodation and easy access to work. For both groups, the seaside town offered a low rent setting that could provide a way to cope with life at the margin in an increasingly unequal society. This is an SSRT attribute that has value when looked at from the perspective of people threatened by homelessness in other more expensive settings. Once again, a widely observable national feature – *the struggle of many to find an affordable home* – finds itself magnified and projected onto the seaside setting.

While waves and cycles of investment made their way through, the low wage, low regulation cash economy of the tourism sector tended to be that aspect of the local economy that *changed least over time*[16]. A significant feature of this is its limited scope for *upward progression*. The resulting shape of the employment profile tends to stay weighted toward a "bottom-heavy pyramid" continuing to feature low wages and flexible contracts.

On this basis, then, *the nature of work* in the Seaside Resort Towns stands out as one of the k*ey* structural drivers underlying the negative health, wellbeing and multiple deprivation statistics. Most towns and cities in the UK have a significant (and growing) segment of their employment assigned to these kinds of working and wage conditions - but it is the *scale and inter-generational longevity* of this kind of work process and the *lack of alternatives* that tends to set the SSRTs apart as a group.

As already noted, attempts at diversification of the economy have been applied to address the employment problems of seaside places. These have spanned decades of assistance under UK and EU regional policy programmes. They have certainly had, and are continuing to have, a positive effect. With these funds and the dedicated activities of the local authorities and development agencies, a

[16] It has also reduced the consumer demand and available spend profiles within which local businesses have to operate. The pressure of demand in local economy is critical both to the balance sheets of local companies and to the investment choice models by which supermarkets and chain stores choose their locations.

number of former resort towns can successfully defy definition as some kind of “mono-economy based on tourism”.

Despite this, however, the data for deprivation in general - and health inequality in particular - shows that the anticipated income and employment trickle down from these active policies of economic development and regeneration has failed to materialise *at a sufficient scale* to offset the further accretion of these challenges for the SSRTs.

From a “social determinants of health and wellbeing” perspective, better market competitiveness is not going to solve the structural factors problem on its own. The causal processes involved go wider and are far too complex, are too inter-connected and too contextually specific.

Having begun with the received story of the seaside town with its narrow economic base and low pay flexible labour market, we now need to open another window on what might be providing the SSRTs with the negative data profile that seems so easily to define them. This time it comes from among those who are, by definition, outside the forces attributable to the labour market.

The older age component in the residential population of the SSRTs

A second major feature of the normal residential population in Seaside Resort Towns as noted by the CMO (Whitty, 2021) is the high proportion of *older age residents*. Most resort towns are revealed as being demographically “top-heavy”. Retiree-incomers of different vintages brought and are still bringing “investment waves” of a very different kind to the SSRTs. These are usually people who, at various points in the past, retired to the seaside at the end of their working lives. For many of them, it was the symbolic power of the seaside place that drew them back to the happy sites of their youth. The coastal environment also has a powerful attraction for them as a potentially secure context for older age living.

Within this group, once again, there is wide variety - largely dependent on prior socio-economic status and asset base. They tend, as a group, to be geographically located away from the tourist core. They occupy different spaces and community settings. They tend to have a strong attachment to their immediate locality[17]. For this group, the environment and “good life opportunities” of a place are critical attributes. For some, this involves access to golf courses, bowling greens, and open spaces for walking etc. For others, it may be little more than the need to find a safe and friendly seaside environment to walk the dog with similar people around them.

Significant numbers of frail elderly people - many with multiple morbidities - exert huge pressure on the entire health and social care public service base in the SSRTs. Their needs are very different from those in the younger age groups living in precarity but they represent a substantial and growing share of the population. In response to this, the SSRTs have a parallel attraction for investment by developers of private care homes and retirement complexes. Both groups – young deprived and frail elderly poor – inevitably exert exceptional pressures on the acute and community health services.

Combining together those older people being looked after in the NHS, those receiving domiciliary care, those in residential care homes, and those being looked after by unpaid carers makes the ***care economy*** a substantial part of the contemporary investment and employment scene of the SSRTs. A

[17] A feature of many seaside towns tends to be what has come to be known as “bungalow land”. The post-war popularity of the single storey home with a garden saw a wave of housing development that persisted into the 1960s. This has a “legacy effect” easily recognisable today in the residential form of most seaside towns especially where the residents of these homes found themselves ageing into relative poverty.

significant feature of care as an employment source is, however, that (with the exception of some elements in the NHS) it tends to offer low paid, precarious, and low-attachment work. Overly economistic appraisals of the sectoral shape of the seaside towns can tend to overlook how important this is. Here the levers for change lie, of course, not in the competitive marketplace but in government public expenditure policies.

The accepted definition of health inequalities relates also to; "*differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status*". Adding substantially to the problems of SSRTs through their demographic shape, is a concern arising from the national scandal of social care[18]. Older people (as well as the disabled generally) are, along with those employed to provide care services, victims of a failed and pernicious system that has been in place for decades. For the SSRTs, this inequity is present at scale and is highly concentrated in local settings. The "crowding effect" on the NHS can also reduce the quality of care for the general population.

In health and wellbeing terms, then, the older demographic of the SSRTs adds a significant, but very different, complexion to the problems they have to face. That sub-set of the population finding themselves *ageing into conditions of poverty and ill health* is growing nationally - with a strong geographical concentration in coastal retirement settings. The national failure to deal with the accelerating problem of *social care for the elderly* is, then, one of those "structural" factors the Secretary of State needs seriously to address in his own policy backyard.

By virtue of what we have just set out, a dominant feature of the SSRTs is that a strong weighting in their employment and income profiles comes from the *public sector* - whether the services are provided through the public service or NHS directly or through contracted private and voluntary sector providers. The dominant SSRT employers tend, in fact, to be the local authorities, education providers and the NHS – all having suffered badly from a decade of austerity.

Part of the health and wellbeing equation for any place is the level of provision required to deal with the challenges it has to face. When that provision is large based on the level of need but at the same time associated with continuing cuts, caps and wages forced to be close to or even below minimum wage standards, there is a disturbing circularity. Many of those living at or close to the margin in the SSRTs are in work but struggling to support themselves and their families on low public sector resourced wages. Those who are out of work can find themselves forced by benefit rules to take low paid jobs – with large numbers going into the care economy. Those unable to work are kept close to or below the margin by punitive benefit rules. There is really not much need to look for deep "structural factors" to explain the outcomes of this system on health and wellbeing inequality.

Summary: A complex and inter-connected array of causes

The context outlined above produces a particular shape to deprivation and health inequality when it comes to the resort towns while, from resort to resort, the narrative and the outcomes will still display wide variety in detail. This is not a one-size-fits-all story. It offers a framework on which it is necessary to hang much more that is *place specific and contextual*.

[18] See: *"A Stain on the Nation" Care for the Old and Vulnerable in England"* and *"Tackling the Issue of Social Care in England: A Three Elephant Problem"* at http://www.peter-lloyd.co.uk/papers-and-blogs

Broadly speaking, the picture has been one of working lives framed around low pay and the contingent labour market[19] for a large proportion in the resort town population. In this respect, the labour market mirrors the picture to be expected of many inner city and old industrial environments. It tends to be reflective of all those places where significant numbers of people are faced with challenging life circumstances and where small area data series normally pick out a condition of multiple-deprivation.

By contrast with the inner cities, however, most seaside towns tend to be geographically more remote and self-contained spaces (many are at the 'end of the train line'). They are not embedded in a wider continuous labour market such as in a conurbation where the scale of opportunity for finding work is an important hedge against job loss. The resort economy also has suffers the downside effects of seasonality. All this makes it more of a special case. Diversification has not generally been able sufficiently to solve the problem though some places have had success. The search for new sources of investment and jobs has to go on but it is not enough and the "wage and quality take" of new jobs has been reducing over time.

Most of the negative conditions the SSRTs have had to face had causes, then, that lay well beyond their ability to intervene. They could and did respond to the challenges in their dominant sector. But with a strong emphasis on the care economy, they were at the mercy of national public expenditure policies. They can be seen as a platform onto which the widespread challenges of the 21st Century have been sharply projected – particularly the rise of economic and social inequality, and the tendency within Neoliberalism for wealth to be rapidly accumulated but poorly distributed across people and places. The SSRTS suffered particularly heavily from a decade of economic austerity and a failed system of social care.

As has been suggested above, many of the big levers of policy in the English context have been at the centre. Shifts in government policy through a decade where inequality has been allowed to rise and where austerity decimated the public sector had a powerful impact on exacerbating those conditions that the Secretary of State for Health is seeking to currently address. "Levelling up", while promoted regularly by the Prime Minister, remains a largely unspecified policy instrument that seems to have little grasp of the true limitations of spatial-sectoral and infrastructure based policies for tackling the embedded challenges of deprived localities.

It is clear from the Chancellor's Spending Review that – apart from some eye-catching allocations of special funds to Red Wall places – there will be no finance available to do much more than maintain the public sector status quo in real terms. Increasing the National Living Wage and removing public sector wage caps will do little more than hold the line and continue the decade-long trend of flat wages overall. Without the prospect of net additional funds, the only serious policy position to take locally is to seek creatively to harvest as much as possible from what is available, and it is to this we now turn.

Harvesting better locally: Some policy lessons from the Covid-19 Experience

The collateral impact of pre-existing heath and wellbeing inequalities is something brought into sharp

[19] The label was first used by the US Bureau of Labour in the early 1980s to describe the way the attachment of people to jobs and of employers to their workers had begun to shift after the oil crisis of the mid-1970s. It represented a new form of labour relations that was much more flexible and that reduced the fixed element in the cost of labour (pensions, welfare benefits and the like). Workers were to be hired shorter term from the external labour market without the employer having fewer responsibilities. There were easier opportunities for severance and an emphasis on paying wages that were "competitive". This saw the rapid rise in sub-contracting, agency workers, and more temporary and short-term contract terms.

perspective during the Covid-19 pandemic, and the depth and persistence of the infection cycle and high death rates mapped even more unequally onto the poorest people in the poorest places[20]. While the worst effects in the pre-vaccination phase of Covid-19 were experienced by the old, another pervasive impact was among those groups living in precarious conditions and in the most congested social and environmental settings[21]. The scale of infections and the plot of the worst effects on health and lives was closely correlated with the index of multiple deprivation at local level. *The SSRTs were particularly at high risk on all these criteria.*

Covid-19 was described in 2020 as a "syndemic"[22]. Its outcomes were attributable not just to *one cause and effect process* but involved a cluster of contextual influences - with the virus as the active agent. This should have the benefit of alerting us to something that policy interventions of all kinds must confront if we are to do better – whether for health inequalities or for other policy domains. *Social systems in action are complexly inter-connected and dynamically interactive* and policy needs to understand and work with this to be more effective.

On the ground there were vital factors at the *micro-spatial scale* to be accounted for in how things played out in the pandemic. The lessons are there to be learned. Keeping a perspective at that same micro-level when moving beyond the crisis, should stimulate some significant changes in the way we do policy for health and wellbeing inequalities. Not least, *acting locally* - challenging though it can be - is a pathway to greater effectiveness. It cannot tackle many of the big issues raised in the previous section - but it can be used to harvest *better and more creative outcomes* from what is available.

The policy and implementation system in place in England produced a local landscape of organisations that, by their design, *segmented* the available means to address locally inter-connected problems. When the *causally-connected components* of a syndemic condition need to be addressed, great local creativity is required to stitch together the necessary interventions. Creative ways are found in practice but silo cultures (dedicated funds, insider languages, internal power structures etc.) present powerful frictional effects. Controlling the Covid-19 infection rates demanded close working between all those at the local level – often with received practice having to be discarded and certainly with *great creativity.*

Calls to act more locally in policy and with better integration have been made for decades. Local voluntary and community sector players have played a critical role in stitching things together, filling gaps and coping with discontinuities. They are still very much with us - as we saw in the crisis. But they too have had had to do this in the face of a quasi-religious market orthodoxy that requires them to act as service providers living off tightly constrained budgets and best value contracts. Their intrinsic *system maintaining* role has been consistently undervalued.

Public Health at the local level (despite being assigned to austerity-squeezed local authorities) showed the way forward - seeing early that the worst pandemic outcomes were being experienced in local micro-spatial settings and moving quickly to engage community, cultural, and faith organisations as key

[20] https://www.theguardian.com/world/2020/oct/07/poorest-areas-of-england-four-times-as-likely-to-face-lockdown-as-richest
[21] https://www.theguardian.com/world/2020/nov/18/poor-areas-of-england-face-permanent-lockdown-says-blackburn-public-health-chief
[22] See: (Horton, 2020); (Courtin & Vineis, 2021); (Mendenhall, 2020); Peter Lloyd and Michael Blakemore (2021), The Covid-19 Experience in England: Eight Essays on the Pandemic and its Management; Chapter 8, p194. Available at https://www.peter-lloyd.co.uk

actors[23] [24]. The broad policy process has much to learn from this and not just in the crisis context and the inclusion of Integrated Health Systems in the new Health and Social Act (2021) seems to indicate that the message is, perhaps, starting to get through.

Government moves toward a new form of policy governance for health and social care: The ICSs

Following on from everything just said, it is at least positive that government has been listening to the chorus of suggestions that top-down, centralised silo policy has to be re-examined. It had become obvious before and certainly during the pandemic that the current systems were unable effectively to deal with complex interactive and interrelated problems and were largely blind to causes at the local level of spatial resolution. This was consistent with the shift in thinking on the social determinants of health inequalities that Marmot had introduced more than a decade earlier.

The most powerful impetus for this transformation in government thinking came, however, not necessarily from listening to systems thinkers. It arose out of very real political pressures in the pandemic. The crisis of social care had been known for decades, but no government had found the political will to address it. It was the disaster in the early stages of the pandemic with excess care home deaths from among patients discharged from the NHS acute hospitals that put the problem firmly on the policy agenda.

The system-based crisis was a disjuncture between a "free at the point of need" NHS, and a social care system delivered largely by market forces under private provision and dominantly serviced from severely cut local authority budgets. Integration between the two systems – one locally delivered and the other nationally framed and delivered through intermediate agencies – was poor and achieved through “workarounds”.

Regardless of these origins, the debate about integration in the overall context of health and social care saw the government move quickly to introduce the new *Health and Social Care Bill* with its emphasis on integration and multi-level governance - emphasising the importance of the local. Vital to this is the insertion of the of concept of “subsidiarity”, which refers to a situation in which policy intervention is carried out at the *lowest level in the system of governance* consistent with efficiency and effectiveness.

The new *Integrated Care Systems (ICSs)* are the primary instruments for the change in emphasis, and the first steps toward their implementation are currently ongoing. At this point, while there are encouraging statements to emphasise different levels of empowerment and voice, it seems to be that applying a *system fix* is the first priority.

It would add too much here to an already over-long paper to explore ICSs in detail and the reader is referred to the stream of vital material on the subject emanating - particularly from the Kings Fund [25] .

[23] The Directors of Public Health in places like Blackburn, Bolton and Liverpool continually strove to make government and the wider health community aware of this.
[24] It is little short of tragic that it was following the Marmot Report in 2010, Public Health was moved to the local authorities in 2012 to take on board the wider social determinants of health inequalities - only to be hit with a decade of swingeing funding cuts that denied it the opportunity to act before the pandemic arrived.
[25] https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained
https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
https://www.kingsfund.org.uk/topics/integrated-care

For our present purposes, we can select out some key features from that emerging literature that link to the storyline for the SSRTs we have just set out.

Some key features taken from the *Guidance from NHS England and NHS Improvement on* the ICS policy that follow the thrust of our earlier discussion are:

- *Working more closely with local communities creates opportunities for health and care organisations to improve the services they provide and increase their impact on population health and wellbeing.*
- *Efforts to connect with, support and mobilise communities are likely to have greater impact if pursued by multiple organisations in tandem, and place-based partnerships can play an important role in this by agreeing a shared approach and co-ordinating action.*
- *The exact division of responsibilities will need to be determined locally given the significant variation in the scale of places and systems and the inevitable interdependencies between them.*
- *Central to these decisions should be the idea of subsidiarity: that decisions should be made as close as possible to local communities, and that activities should only be led at scale where there is good reason to do so.*
- *Much of the work to deliver more integrated services needs to happen at place level through collaboration between providers of all kinds.*
- *ICSs are made up of their constituent places. They should operate as a mechanism for working across places to bring benefits of scale rather than as distinct entities in a hierarchy.*

There is clearly an enormous amount of work to be undertaken to take these entirely laudable statements of intent from the fine words into working practices in a grounded context. Those charged with launching the ICSs seem to be of the view that at least two years is likely to be needed, and there is a danger that reorganising the system may take precedence over the desperate need to do better for people. As we have been suggesting, tackling health inequalities is not just about having a better care system or more effective care pathways.

Taking a wider view than Health and Social Care

What we are seeing in the government approach at this point is an earnest attempt to fix the health and social care system. What needs to be added to the exercise, however, is that wider body of thinking that Marmot introduced. While fixing the health and social care system along the lines of the ICSs will be welcome, it falls into the critique of being necessary but not sufficient. The Marmot view was that it was in the early years of life and during education that the social determinants of young people and families' health are engineered: contingent to the circumstances of income and the quality of employment; exposure to air pollution and poor housing. To this needs to be added the experiences of ageing; and the additional biases applied in the context of gender and ethnicity.

Taking the list above, income and quality of employment, the quality of early years living and education, air pollution and poor housing are all outside the frame of reference of the Health and Social Care Bill and beyond the remit of the Secretary of State for Health and his Department. Fixing the health and social care system will, of course, be vital but, by itself, it will not address the causalities that Marmot identified clearly as being so much wider than the system of health policy per se.

It is also the case that many of the most important levers for change are not those fixable by a more integrated and locally sensitive system of health and social care – welcome though that will be – but lie firmly at the centre in the policy that government enacts. Central policies with respect to the labour market, education, planning and the environment, housing, social care and social inclusion in the wider sense, are those that create the framework against which lives are lived out in places like the SSRTs.

The inequalities that give the resort towns such a poor standing in the data on unemployment, educational outcomes, housing quality, and health fairness, are matters of social justice. Measures to address them are about both fairness and about social cohesion as a public asset. So, we should not get too carried away by the fact that the government of the day is looking to introduce local partnerships and subsidiarity into its revised systems for health and social care. This is not to say that there is nothing constructive that can be done to improve things.

Once again, we can turn to Marmot. He set out his six principles to "reduce the social gradient in health". They do not restrict themselves to "health exceptionalism" but go out widely to the immanent causes we have been discussing:

- *Give every child the best start in life.*
- *Enable all children, young people and adults to maximise their capabilities and have control over their lives.*
- *Create fair employment and good work for all.*
- *Ensure a healthy standard of living for all.*
- *Create and develop healthy and sustainable places and communities.*

If we wanted to address the issue we have explored for the SSRTs, tacking all these issues together would certainly make the difference. That they have not been taken up at the centre is, of course, because their content is *deeply political* and goes to the heart of what the electorate sees as what is to be valued in contemporary society.

We return to the key question of *"what is to be done?"* Perhaps the first requirement is to *be realistic* about the possibilities at this point in time. We are still in a pandemic. We have suffered enormous damage to the economy and to public services because of it. We know now from the Chancellor's Autumn Spending Review that the public purse is not something we can turn to for the order of new funding needed to address long standing structural issues for place like the SSRTs.

What we also know, however, is that the pandemic experience changed mindsets. People clearly saw the inter-connectedness of their lives and the degree of their dependence on others. They were made aware of the scope for and the importance of coming together locally and in their communities of place and culture. They saw the limits to the powers of the centre to intervene effectively in a lethal public health crisis, and how little information was available to know what was going on at the micro-spatial level. People learned resilience and solidarity in the face of an existential crisis.

So, what can be done in the local context to make the best use of the new-found realisation of its importance? What can be done to supplement and complement the actions of those local bodies charged with helping the recovery? What can be done to give voice to the consumers of policy services to help co-design and co-produce better interventions on their behalf?

Re-thinking the system: Fostering inclusive voice and engineering shared views of needs and provision

Ensuring the best possible health and wellbeing of the entire community is something we can surely all agree on while we struggle to recover from the traumas of Covid-19. The lessons of the pandemic provided a unique opportunity to mobilise consensus around the idea of doing better. Covid-19 cruelly revealed our health vulnerabilities and, in addition, the realisation finally dawned that we need to take seriously the challenge of the global climate emergency. The old normal was, then, exposed as having little to recommend it and we need to re-imagine a future that is both more inclusive and sustainable.

This is, however, not just something for others to do but demands a contribution from each individual. There is a need for greater personal and community engagement. As a key part of this, we have to be willing to debate radical ideas[26]. We need to move on, for example, from thinking of public services as just another money-measured system of production in the fiscal spreadsheet. The maintenance of health and wellbeing in an environmentally sustainable society can no longer just be a function of how much can be afforded for it from the national growth of GDP in a market economy – especially when growth itself has to be subject to the demands made on the planet.

To have a broad ambition for all to live healthier and better lives has to be much more than grand rhetoric (a challenge too for COP26). We have to find a way to re-think what we value as a society. In doing this, the whole idea of what we currently see as the public services has to be in the frame. *"We are doing the best we can within the limits of what we can afford"* has been a standard script for decades of Chancellors at budget time. As a product of this, we are currently confronted with an enormous crisis of care in all its forms in the UK. This did not just appear with Covid-19. The problems of inequality and deprivation have continued steadily to grow and, with the acquiescence of the electoral majority, the means available to deal with them have been dramatically reduced.

The story of the SSRTs has another structural cause that goes directly to the way, as a nation, we view those in society who are experiencing health and wellbeing inequalities and how we allocate the means to support them. The seaside resorts can be seen as a bellwether - which is "something that shows how a situation will develop or change"[27] - for the society we are still in the business of constructing. Turning back those complex causal processes in any significant way demands something much more profound than a new approach to local policy. That is why, realistically, we focus attention, in what follows, on "harvesting" the best from what is available by means of locally combined efforts.

For a given place that has some local meaning (and not just some pre-assigned administrative territory) what, then, might be the script capable of drawing people and institutions together around the topic of better health and wellbeing? Fortunately, Marmot gave us a clear guide to what the headlines for such a project might be, and some places are already adopting it - Coventry and Salford for example[28].

The great truth is that the causal chains running through the Marmot list emerge from the historical story of economy and society projected over place and time onto the rolling screen of daily life as lived. Their complexity is simply absorbed as people in place just "get on with it" - while the academics and

[26] Hilary Cottam gives a strong lead on this. See: https://www.hilarycottam.com/radical-help/ and https://www.hilarycottam.com/the-radical-way_shifting-the-social-paradigm/
[27] https://dictionary.cambridge.org/dictionary/english/bellwether
[28] https://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city
https://www.partnersinsalford.org/media/1467/locality-plan-2020-to-2025.pdf

researchers explore patterns, shapes and theories as they look for structural factors and debate theories about how this complex world is to be understood.

These understandings are often simplified as a model, political project or rulebook about how governments should intervene to achieve their aims on our behalf. The people "getting on with it" both know and do not know. They are the ones who see and live out the detail - but generally they leave it to the "experts" and politicians to decide how things should be understood and organised on their behalf.

To move forward in the context of a global public health crisis and a climate emergency, there is a need to come to terms with the fact that we live at a moment of *epochal change* under a complex, interconnected and dynamic system that does not lend itself to simple theorisations. We need to find better ways to capture the requisite variety to observe the complexity of the system and to devise tools to work with it. Above all we need to see how it works in context.

An obvious way forward would be to widen the *constituency of voice* about what is going on locally and in context. Covid-19 taught us the lesson. Only when we were able to see the micro-scale progression of infections in certain local places, could we understand the idea of "syndemic" – *combined and additive forces acting in concert*. Simplified regional maps had stripped the evolving process of the contextual knowledge needed to intervene effectively.

In our exploration of the *century-long history of disadvantage* across the SSRTs, we can see that none of the individual elements in the list is simple. Each involves a constellation of contributing factors. They cut across the traditional silos and hierarchies of contemporary public administration. There is internal variability based around class, gender, ethnicity, demography and place specificity. The public services and the voluntary community sector (VCS) strive to improve things but from within their established budget lines and areas of responsibility.

A "Pact for Health and Wellbeing"

What then could be done to capture a shared and more sophisticated view of how to drive forward the Marmot principles in a given local context? What would be needed for people and players at all levels in the SSRTs to better understand what might be required – individually, in the community; in the public services, and in expectations of what the state and private business should contribute? What might be relatively simple to insert that might begin to construct and mobilise a better sense of common purpose? What sort of intervention would it take to induce a greater sense of ground truth and realism into the policy debate at a time of crisis and when there is so little prospect of net new resources from government?

During the pandemic, horizontal collaborations often had to take place in spite of the regular governance system. To do this under *force majeure* would have required the trust of the funders, budget holders and practitioners under some – largely uncodified - agreement. The proposition here is to widen and upgrade that same idea by introducing the idea of a *Pact for Health and Wellbeing* that would apply across a variety of local situations and players. Pact as a concept is defined as follows:

> *A formal agreement between two or more people, organizations, or governments to do a particular thing or to help each other*[29].

[29] https://www.collinsdictionary.com/dictionary/english/pact

Normally, we hear of Pacts in the higher reaches of international politics but, as the definition above indicates, it can be applied in a wide variety of situations. The simple image is of people sitting round a table or together in a meeting place[30]. The ambition is to construct some form of agreement on a given subject that everybody could sign up to and covenant to facilitate the steps needed to achieve the aims. It is ideal where there is some superordinate objective that can be agreed to as a *statement of combined intent* and where the means to achieve it are *complex and variable*.

At the height of the unemployment crisis of the late 1990s, the EU grasped the concept of the Pact and, in particular, its power for clear focus at one end and liberating the creativity of local players at the other. The *Territorial Employment Pacts (TEP) programme* deployed the idea to 89 experimental local sites as a device to unlock creative solutions. Over time, the TEP concept went on to become embedded into national policy frameworks. Two EU nations – Austria and Hungary – adopted the idea fully, kept the label and have become sites for best current practice [31].

Closer to home and arising directly out of the EU initiative, the idea of a (Territorial) Pact was introduced under the *Rhyl Going Forward* initiative in a Welsh SSRT with high levels of multiple deprivation. The overarching objective in this case was to take a fully-connected approach to the development of the town to deal with its issues of unemployment and social exclusion [32]The Pact was used to bring together all the players with an interest plus community groups under the stewardship of Denbighshire County Council. The value added of the Rhyl Pact was to find new ways to tackle what were clearly understood to be complex and inter-connected causalities. The idea was to bring all the players together to see how they could join up their actions in more creative ways. Central to this was the need creatively to adjust silo-based budgets while still respecting the formal obligations of the players.

Taking this idea to the SSRTs more generally, it is a given that across these places there is already a great deal going on under the banner of health and wellbeing initiatives. A long list would emerge of local authority, health service, VCS and community projects and other activities dedicated to particular target groups or "situations of concern". Bringing them together to declare their over-arching objective through signing up to a locally constituted and co-designed Pact would be a primary step toward privileging *a more holistic and joined up approach*.

While this is the component of the Pact approach that deals with the "coming together" of identifiable players be they public sector, VCS, businesses or neighbourhood-level bodies, there is a need to go further in cases like the SSRTs. The voices of individuals and families in the transitory or outsider groups that may lie outside the organisational framework will be particularly important to understanding where significant issues may lie. Creative interventions here may represent a special SSRT contribution. Making contact would be a challenge and it may be necessary to prepare the ground by the deployment of something like a corps of community volunteers or outreach workers. A Pact discussion would probably have come up with this.

Achieving genuine inclusivity should be a primary operational aim of a *Pact for Health and Wellbeing.* and, beyond the creation of the Pact community and the establishment of the broad statement of common purpose, the *operational* objective would be to incentivise people across the board -

[30] The new communications technologies so widely applied in the pandemic can be a game changer. We can now think in terms of a low cost *network* to connect Pact participants visually and of an *active internet platform* for discussion, debate and the exchange of content.

[31] https://ec.europa.eu/regional_policy/sources/docgener/evaluation/doc/tep_report1.pdf https://www.google.com/search?client=firefox-b&q=Local++development+and++territorial++employment+pacts+-+Report+of+the+seminar++Rome%2C++4-6++May++1997

[32] https://www.denbighshire.gov.uk/en/documents/your-council/strategies-plans-and-policies/plans/town-and-area-plans/town-and-area-plan-rhyl.pdf

individuals, organisations, businesses and institutions - to make their best efforts to *share stories, experiences and practices* around the central focus.

Some of this should involve the collection of a dedicated suite of local data to set a baseline and to track outcomes by group spatially and over time. The inability of the Standard Data series to see what has been going on at a sufficiently granular level of resolution does much to explain why we had to wait for a pandemic to alert us to the inter-connected causalities that condition the circumstances of the most deprived groups.

In full recognition of the importance of the social determinants of health, the list of participants to a *Pact for Health and Wellbeing* would need to be very wide - to include education, housing, employment, and welfare benefits, debt counselling, children's' action and so on. Not least, the value of creating a Pact would be to generate locally-framed conversations and ideas that come *from the ground up* and not just to consult about what to make of policies that arrive top-down and from other levels of jurisdiction.

Signing up to Pact would be an invitation to initiate a "hearts and minds" venture rather like Coventry's Marmot City. By means of an agreement to participate around a core objective, it could open the door to a more creative dialogue framed within a more realistic appreciation of the situation on the ground. The very act of setting out simply what the participants can commonly agree upon would, of itself, be a constructive journey toward the creation of that essential ingredient of any Pact – *trust*. At its best, it would open a pathway to greater inclusivity, legitimacy and trust as a recognisable *local social capital asset* with considerable value. The Preston Model has the same basic idea at its core[33].

An all-inclusive *Pact for Health and Wellbeing*. would not, then, seek to set up some new entrant organisation. It would work through the framework of those entities already in place – encouraging them to mould their behaviours and activities. The move toward full inclusivity would make them better able to address what is needed to improve and sustain local health and wellbeing. They would be enabled to *sense gaps better* and *be more creative* in the design of solutions. Operating at its best, a Pact would act as a device: i) to privilege "thinking out of the box"; ii) to mobilise inclusive commitment and learning about causal realities and iii), by collecting better data, to be able to deploy better planning and analysis *"horsepower"*.

But realism would be essential. The first task would be to energise local players to *harvest the best possible outcomes* from within the existing allocation of resources and competencies. Just having people and organisations at all levels think about and be willing to sign up to the idea would be a vital step forward in challenging the hegemony of the top-down silo approach. If the Secretary of State really wishes to tackle the factors that can lead to a century long history of disadvantage and deprivation in the SSRTs, he could do worse than find a way to empower the people and organisations on the ground to help government get much better view of the "structural causes" he wants to identify.

Bibliography

Beatty, C., & Fothergill, S. (2003). THE SEASIDE ECONOMY The final report of the seaside towns research project.

Beatty, C., & Fothergill, S. (2004). Economic change and the labour market in Britain's seaside towns. *Regional Studies*, *38*(5), 459–478. https://doi.org/10.1080/0143116042000229258

Courtin, E., & Vineis, P. (2021). COVID-19 as a Syndemic. *Frontiers in Public Health*, *9*.

[33] https://www.preston.gov.uk/article/1791/The-definitive-guide-to-the-Preston-model

https://doi.org/10.3389/FPUBH.2021.763830/FULL

Farr, M. (2017). Decline beside the seaside: British seaside resorts and declinism. *Mass Tourism in a Small World*, 105–117. https://doi.org/10.1079/9781780648545.0105

Health Equity in England: The Marmot Review 10 Years On - The Health Foundation. (n.d.). Retrieved October 26, 2021, from https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Horton, R. (2020, September 26). Offline: COVID-19 is not a pandemic. *The Lancet*. Lancet Publishing Group. https://doi.org/10.1016/S0140-6736(20)32000-6

Massey, D. (1995). *Spatial divisions of labour: social structures and the geography of production*. Retrieved from https://books.google.com/books?hl=en&lr=&id=GEtdDwAAQBAJ&oi=fnd&pg=PR10&ots=_nBUQWlKe_&sig=T5rFFS19kQIA3XMsQaqYpQfALiA

Mendenhall, E. (2020). The COVID-19 syndemic is not global: context matters. *The Lancet*, *396*(10264), 1731. https://doi.org/10.1016/S0140-6736(20)32218-2

Pike, A., Rodríguez-Pose, A., & Tomaney, J. (2007). What Kind of Local and Regional Development and for Whom? *Regional Studies*, *41*(9), 1253–1269. https://doi.org/10.1080/00343400701543355

Rodríguez-Pose, A. (2018). Andrés Rodríguez-Pose The revenge of the places that don't matter (and what to do about it). *Cambridge Journal of Regions, Economy and Society*, *11*(1), 189–209. https://doi.org/10.1093/cjres/rsx024

Whitty, C. (2021). *Chief Medical Officer's Annual Report 2021: Health in Coastal Communities - Summary and recommendations*. Retrieved from https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health