Policy Report Series

Townscapes

4. England's health inequalities
The declining economic fortunes of many towns, and the chasm that divides the experiences and outlooks of many of their inhabitants from the metropolitan centres where wealth and power have become concentrated, are issues of growing interest in political life and public policy.

In the UK, the preponderance of support for Brexit among town-dwellers, and the countervailing values of many young urbanites, have sparked a deep debate about how and why towns are locked out of the circuits of growth in the modern economy, and how the inequalities associated with economic geography can be more effectively tackled. It is becoming increasingly clear that the ongoing COVID-19 crisis is having a significant impact upon the experience and health of people living in different parts of Britain.

The Townscapes project launched at the Bennett Institute brings together a variety of different data sources to offer a deeper analysis of how towns are faring across the regions and nations of Britain. It aims to step away from the generalisations and dogmas that infuse much of the contemporary policy debate and offer instead a more finely grained picture of how different towns relate to their wider regions and nations, as well as to their nearest cities. It showcases the merits of a more granular and regionally rooted perspective for our understanding of geographical inequalities and the kinds of policy needed to address them.

Analysts at the Bennett Institute have pulled together a variety of different data sources - from the ONS, Public Health England and NHS Digital - and created new indicators to measure the relative economic performance of towns, and compile a picture of changes in levels of public service provision. In this particular report we measure the health of towns as well as their long-term trends and key environmental drivers of health.

On the basis of these findings, we argue that policy makers need to consider multiple town categorisations, to get beneath the broad groupings that have become so dominant in this debate such as ‘university’, ‘coastal’, or ‘post-industrial’ towns. Instead we adopt more useful data-driven typologies such as access to key drivers of health outcomes and deprivation levels.

These reports bust some of the prevalent myths about towns and their fortunes since the recession of 2007-08, and lead us towards a better appreciation of the very different circumstances and factors which affect the lives and opportunities of those who live in them. In addition to the insight and evidence which each supplies, we point policy-makers to ideas and proposals that are tailored to the regional and national circumstances which are pertinent to the townscapes of modern Britain.

Professor Michael Kenny
Director of the Bennett Institute, Cambridge University
Key Findings

• Health outcomes in towns are, compared with cities, moving in a worse direction in the last few years – the previous pattern of rising life expectancy has stalled or gone into reverse in many English towns.

• But we should be much more aware of the markedly different health experiences and outcomes between towns; on some measures inequalities between them are much greater than the average difference between towns and cities.

• The most deprived set of towns is much worse off than the least deprived on a number of key measures such as life expectancy, child obesity rates and the prevalence of lung cancer.

• The built environment of towns, including their provision of green spaces and the kinds of retail options they provide, including fast food outlets, are closely linked to their inhabitants’ health outcomes.

• GPs play a key role within local health provision; yet there are some notable divergences between a town’s level of need and the medications prescribed for its residents.

• The COVID-19 crisis is having a major impact upon England’s towns. Access to green space, which is crucial to the mental and physical health of a population, especially during lockdown, is very unevenly distributed within them. There is an overriding need for policies to address the large and widening gaps in the health and economic fortunes of many towns, and these should be integral to the ‘levelling up’ and economic recovery agendas.
Introduction

The very different positions of regions across Britain in terms of employment opportunities, skills and educational outcomes have all moved up the policy agenda in recent years, but inequalities in health outcomes have been less salient as an issue. This has in recent times begun to change. The UK government’s Towns Fund prospectus, for instance, makes reference to health and wellbeing as key goals for the investments it will make (MHCLG, 2019).

This new report seeks to supply a richer and more evidence-based appreciation of the spatial variation of various major health outcomes, focusing in particular upon the strikingly divergent experiences of people living in poorer and wealthier towns across England. In the context of the ongoing COVID-19 pandemic, an understanding of these underlying patterns, and an appreciation of the factors and dynamics that generate such poor outcomes for people living in some of our most deprived places, is going to be vital. The pandemic is exacerbating these disadvantages and having a much greater impact upon the lives and health of those who are currently most vulnerable to conditions of deprivation.

The geographical patterning of health outcomes has become more marked in the last decade. The recent Marmot 10-Year Review (Marmot et al., 2020) highlights increasing inequalities in life expectancy as well as a marked recent decline in the health of many deprived populations. And, the UK2070 Commission (2020) reported ONS (2016) data showing a ‘19-year difference in healthy life expectancy for men and women between the most prosperous and most deprived areas’. This means that there is a larger gap in the years of ‘healthy living’ for people living in these places, than in life expectancy itself.

There are marked differences in health outcomes between large metropolitan centres and towns, as various studies have shown (Centre for Towns, 2018a; O’Connor, 2017; Select Committee on Regenerating Seaside Towns and Communities, 2019). But it is important, we would suggest, not to focus solely upon this comparison. In particular, the growing gulf between different kinds of English town should be a subject of much greater concern in the public health and public policy communities.

As Figure 1 illustrates, recent increases in life expectancy have been happening more slowly in towns than cities, overall. However, differences between towns and cities in terms of life expectancy are, on average, pretty small.

Image, above: Thank you NHS
Figure 1 also shows that that the average female life expectancy of people in towns was for many years higher than in cities, but that gap has now closed, and begun to reverse in the last five years. Male life expectancy shows a similar trend, but is less marked. Why it is that women are suffering a steeper decline in life expectancy is itself an important question. Marmot (2020) highlighted a sharp fall in female life expectancy in the most deprived areas of England, and a slight rise in male life expectancy in those same areas.

Important as these comparative trends are, there is overall not a huge difference between towns and cities on this measure. And the overarching focus on this comparison has served to obscure growing inequalities between towns. Our analysis shows that people living in the most deprived towns in England will on average spend 12 fewer years in good health than the inhabitants of our wealthiest towns. We explore this comparison in the remainder of this report, highlighting other indications of a growing divide between these places, and examining some of the key environmental and social determinants of poor health outcomes.

**Figure 1:**
The Closing Gap in Life Expectancy between Towns and Cities

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**Source:** ONS - Life expectancy at birth (accessed via Public Health England Local Authority health profiles); House of Commons Library - City & Town Classification of Constituencies & Local Authorities

**Notes.** Town classification is constructed by Baker (2018) and is based on the population sizes of the different conurbations within each English Local Authority. We use the summary classification and aggregate all town sizes in our categories.
Comparing Towns

Figures 2 and 3 illustrate this large gap in healthy life expectancy for inhabitants in more deprived and more affluent towns. For both women and men, the gap between the most and least deprived towns is around 12.5 years. The towns with the lowest average healthy life expectancy for women and men are the same: Thrunscote, South Kirkby and Oldham.

Figure 2:
Female Healthy Life Expectancy

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1. The multiple deprivation index includes measures of health as one of their seven domains of deprivation. As such, we would expect some level of correlation between health outcomes and deprivation levels and can attribute part of this to a double-counting of ‘health’. Towns are measured, here, as any Built-Up Area (Sub-Division) with a population over 5,000 which is not a core city as defined by the House of Commons Library (made accessible at https://github.com/thomasforth/incomeintowns).
2. Latest data on healthy life expectancy comes from the years 2009-2013. The data for deprivation ranking comes from 2019 and therefore comes from a different period to healthy life expectancy data.
Figure 3: Male Healthy Life Expectancy

It is also worth noting that there is very little difference in the healthy life expectancy of towns’ male and female populations. Healthy life expectancy estimates years spent in “very good” or “good” health, and is based upon people’s reported perceptions of their health (ONS, 2020a). Women have a longer overall life expectancy but a similar ‘healthy life expectancy’, and as a result are expected to spend a larger percentage of their life in poor health (Public Health England, 2017).

These figures relate to physical health. There are very few measures of mental health that are recorded at this geographical scale. An exception to this is the number of hospital admissions for intentional self-harm. Figure 4 shows a clear relationship between levels of hospitalisation for self-harm and how deprived a town is.


Notes: Data has been aggregated from the MSOA scale to Built-Up Area boundaries (with sub-divisions) and has large 95% intervals at this geography. Consequently, these represent, at best, estimates for the true value. Healthy life expectancy (HLE) is the average number of years that an individual might expect to live in “good” health in their lifetime. The health state used for estimation of HLE was based on self-reports of general health at the 2011 Census specifically those reporting their general health as very good or good were defined as in good health in this context.
The worst place for having unexpectedly high rates of hospital admissions relating to self-harm is Blackpool, which is also the 34th most deprived town in England. But the relationship between deprivation and mental health outcomes is not absolute. East Tilbury in Essex is in the quartile of towns experiencing the most deprivation but has the fourth lowest rate of hospital stays for self-harm. Although there is a clear link between deprivation and self-harm, there is no simple correlation between them. A single measure of deprivation based on an area’s level of employment, income, housing, health, education, environment and crime cannot encompass all the factors that will affect the mental wellbeing of a population.
CASE STUDY
Comparing Two Coastal Towns with Older Populations: Sidmouth And Jaywick

- Both Sidmouth and Jaywick are amongst the oldest towns in England with over a quarter of their populations aged over 70 years old.
- Both towns are also coastal towns: Sidmouth in Devon and Jaywick in Essex.
- Sidmouth and Jaywick also both have historically large tourism industries.
- Sidmouth has a relatively affluent population.
- Jaywick is one of the most deprived places in the country.
- The towns have almost opposite outcomes in terms of the health of their inhabitants despite similar geographies and demographic profiles.

Below are the health profiles of Jaywick and Sidmouth mapped on to a density plot of all of England’s towns. The light green box represents the range between the 25th and 75th percentile town with the median value marked by a line in between.

- **The more affluent town, Sidmouth, is better than average for most health outcomes.**
  » Sidmouth has a healthy life expectancy in the top 25% of towns in England for both female and male populations
  » At around 12%, Sidmouth’s child obesity rate is relatively low – and half that of Jaywick’s.
  » Interestingly, both towns appear to have relatively high rates of hospital stays for self-harm.
- **Jaywick, on the other hand, stands out for its poor health outcomes.**
  » It has the second highest incidence of hospitalisations for self-harm of any English town, behind Blackpool.
  » Its female and male inhabitants can expect, on average, fewer than 60 years of healthy life.
Comparing Towns

Levels of reported 'general health' appear to correlate quite closely with how deprived a place is. In two towns, Jaywick and Mablethorpe, less than 30% of people report being in 'very good' health. And both exhibit signs of poor health on other indicators too, such as life expectancy and rates of child obesity.

By contrast, several places have around 60% of people reporting 'very good' health. The town with the highest rate of self-reported 'very good' health is Camborne in Cornwall.

Figure 5: Self-reported Health

![Image of Jaywick, Essex]

Notes. Latest data on self-reported health comes from the 2011 census. The data for deprivation ranking comes from 2019 and therefore comes from a different period to the self-reported health data.
Alcohol-related hospital admissions in towns vary greatly by geography, and are strongly correlated with deprivation. This is a measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition (Public Health England, 2020). Towns in the North West of England appear to be worst off on this measure, with the five worst performers all located there -- Eccles, Salford, Ince-in-Makerfield, Birkenhead and Bootle.

**Figure 6:** Alcohol-related Harm Rate

![Image](image.png)

*Image, above:* Sailing on Scotman’s Flash near Ince-in-Makerfield

**Figure 6.**


**Notes:** Data has been aggregated from the MSOA scale to Built-Up Area boundaries (with sub-divisions) and has large 95% intervals at this geography. Consequently, these represent, at best, estimates for the true value. The figure displays a value which is standardised for the different age profiles of places. A value of 100 would mean the town has an expected level of hospital admissions, values higher than 100 indicate more than expected admissions and values lower than 100 indicate fewer than expected hospital admissions.
Comparing Towns

The incidence of lung cancer in England’s towns also varies considerably, reflecting different levels of smoking among their inhabitants. And on this score too, there is a strong correlation with deprivation.

Figure 7:
Lung Cancer Incidence

Figure 7.
Notes. Data has been aggregated from the MSOA scale to Built-Up Area boundaries (with sub-divisions) and has large 95% intervals at this geography. Consequently, these represent, at best, estimates for the true value. The figure displays a value which is standardised for the different age profiles of places. A value of 100 would mean the town has an expected level of hospital admissions, values higher than 100 indicate more than expected admissions and values lower than 100 indicate fewer than expected hospital admissions.
One final, telling indicator of town health is childhood obesity, recorded at year 6 (ages 10-11). Figure 8 shows that children in the most deprived town have an average obesity rate 11.9 percentage points higher than in the most affluent – which amounts to almost twice the number of obese children. At one end of the spectrum on this measure is Epsom, a commuter town in leafy Surrey; and at the other end is West Bromwich in the West Midlands.

**Image, above:** The outdoor market, West Bromwich

**Figure 8:**
Childhood Obesity

**Figure 8.**

**Notes.** Children are classified as obese if their BMI is on or above the 95th centile of the British 1990 growth reference (UK90) according to age and sex. Data has been aggregated from the MSOA scale to Built-Up Area boundaries (with sub-divisions) and has large 95% intervals at this geography. Consequently, these represent, at best, estimates for the true value.
CASE STUDY
Child Obesity in the West Midlands: West Bromwich, Wednesbury, Tipton, Dudley and Bilston

- There are clusters of towns which appear worst off for different health outcomes in the North East, North West and West Midlands.
- In the West Midlands there are a number of towns clustered together that appear unhealthy on most indicators: West Bromwich, Wednesbury, Tipton, Dudley and Bilston.
- They have particularly high relative levels of childhood obesity.
- These five towns make up half of the worst ten towns in England for childhood obesity rates.

Below are the child obesity rates of West Bromwich, Wednesbury, Tipton, Dudley and Bilston mapped on to a density plot of all of England’s towns. The light green box is a box plot representing the range between the 25th and 75th percentile town with the median value marked by a line in between.
England’s Most and Least Healthy Towns

Towns often perform variably on these different measures so generalisations about particular places should be avoided. But there are also some strong and troubling clusters of poor health outcomes in a number of them. And there are some strong regional concentrations of poor health. In this section we identify which towns are, on these measures, the healthiest and unhealthiest places to live.

Poor health is not a problem reserved for any single ‘type’ of town. Some of the least healthy towns are satellite conurbations just outside Manchester and Liverpool, for instance Salford, Birkenhead and Kirkby. And some are coastal towns, like Newbiggin-by-the-Sea and Jaywick. And some are much larger places, like West Bromwich, and some very small, like Bideford.

But there are some notable regional patterns at work here. Below we map the locations of the 20 best and worst performing towns on a number of key measures of health. And this suggests that, with a few notable exceptions, healthier towns are more likely to be based near to London, and the least healthy are spread across the North of England.
 Female healthy life expectancy is highest in towns which are primarily located in London’s commuter belt, with a few exceptions. But the places with the lowest healthy life expectancy for women are more geographically spread. The North East, West Midlands, Yorkshire and the North West all include clusters of towns that do particularly badly on this measure. Meanwhile Hale, just South of Manchester, appears to have a particularly high healthy life expectancy – a reminder that simple generalisations about Northern and Southern places do not hold up.
While there are some regional differences apparent in this data, it is important to appreciate that different kinds of health outcome affect different parts of the country to varying degrees. For example, as figure 10 shows, none of the worst towns for child obesity are in the Merseyside/Greater Manchester areas. On this measure the worst performing places are clustered in the North East and West Midlands. Figure 10 also highlights the poor health outcomes of some South East towns like Tilbury and Waltham Cross.
Of all the measures considered here, hospital admissions for alcohol-related reasons is the most clearly concentrated in geographical terms. The North West and North East include nearly all of the worst-performing towns on this measure, while eighteen of the best-performing are located south of Peterborough.
CASE STUDY
Two outliers in rural East of England: Swaffham And Soham

Below are the health profiles of Swaffham and Soham mapped on to a density plot of all of England’s towns. The light green box is a box plot representing the range between the 25th and 75th percentile town with the median value marked by a line in between.

The plots below show that it is important to look carefully at different measures of health when comparing places, even quite similar ones. Soham is fairly average on quite a number of health outcomes and is middling in terms of deprivation. But it has an unusually high rates of hospitalisations for intentional self-harm.

In some key respects Swaffham and Soham are quite similar – they are both small towns in the same region of England, relatively isolated from large urban areas and they have similarities in some of their health outcomes. But, if we look carefully, we can see some very different outcomes in terms of, for instance, child obesity.
The Environmental Determinants of Health

There are many different determinants of good health, and a good deal of research has established the significance to it of factors like employment and education (Marmot et al. 2020). There is also a growing focus on the range of other environmental factors, including access to open-air spaces, and good quality housing (Kabisch, 2019; Baker et al., 2016). Some studies have found that the density of fast food outlets in a place is linked to the prevalence of obesity in it (Burgoine et al., 2018). In this section we look at the geographical distribution of some of these influences.

Figures 12 and 13 indicate the likelihood that a town has a green area or park within its boundary. We find that the most affluent towns, which are often, as we have seen, also the healthiest towns, are far likelier to have a green space within them. And, as figure 13 shows, the least healthy towns – measured by responses to a question about general health in the census - are very unlikely to have a commons or park which is easy to access for their inhabitants. The causal nature of this relationship is hard to establish, but the correlation here is very striking. In the context of the ongoing coronavirus pandemic, and the growing focus upon the need to exercise daily, away from other people, this is a salutary and important finding.

Figure 12:
Green Space and Town Deprivation

![Graph showing predicted probability of a town-based park versus multiple deprivation rank]

**Figure 12.**

Notes. ‘Green Space’ is any classified ‘commons’, ‘municipal parks and gardens’ or ‘country and national parks’. Towns are classified as having a green space if any of the locations of these green spaces fall within their built-up area boundary. The figure plots the results of a simple binomial regression between green space and deprivation rank.
Figures 12 and 13 also show that, overall, very few towns have commons or municipal parks – as defined by Ordnance Survey - within their built-up area boundaries. This, we should note, is partly a consequence of town boundaries being drawn around land that is developed. However, it is revealing that the vast majority of towns have not had green spaces incorporated within their design and development. Furthermore, those places that do have parks and large green spaces in their centres are much more likely to be affluent and healthier.
Another potentially important contributor to bad health outcomes in a town is the kind of retail options contained within it, particularly when it comes to fast food outlets. There is a correlation in the data between those towns that have a higher number of these types of food providers and worse health outcomes for their populations. This important finding confirms other studies that have examined in more depth the effects of living near fast food shops on people’s consumption habits (see. Fraser et al., 2010). Figures 14 and 15 show that there is a slight relationship as more deprived and unhealthier towns have more of these outlets per capita.

**Image, above:** Fish and Chip Shop, Worthing

**Figure 14:**
Density of Fast Food Shops in Towns

*Figure 14.*
The environmental factors associated with different health outcomes are distributed unevenly. More deprived towns are much less likely to have a green town centre and much more likely to have high numbers of fast food outlets than their wealthier counterparts. And both of these factors are likely to contribute significantly to the widening of geographic health inequalities in England.
We also examined data relating to the drugs that GPs prescribe for patients living in different parts of the country, and observe some striking patterns in towns across England. We wanted to find out if towns with populations that had higher rates of mental health problems were also those where higher levels of anti-depressants were prescribed, and tried to discover if the same was true for physical conditions, like obesity. Our analysis suggests that this is not currently the case, and reveals instead a striking discrepancy between levels of need and the pattern of drug prescription in many towns. For example, it appears that there is very little association between levels of antidepressant prescriptions and hospital stays for self-harm in a place. There may well be a variety of different factors which can explain this outcome. In his recent study, Baker (2016) finds that ‘rates of antidepressant prescribing are lower in areas with a higher proportion of Black or Asian people’. Other research investigates a wider range of environmental and personal factors that may explain this kind of anomaly (Walters, Ashworth and Tylee, 2008; Taylor et al., 2015). Whatever the causal dynamics behind them, these findings suggest a troubling picture of the inability of the healthcare system to address the relative needs of different kinds of town.
Figure 16:
Town Spending for Antidepressant Prescriptions and the Number of Hospital Admissions for Intentional Self-harm


Notes. Data has been aggregated from the MSOA scale to Built-Up Area boundaries (with sub-divisions). Consequently, these represent, at best, estimates for the true value. Prescription data is built up to BUASD geography using the number of people registered at each GP patient data from LSOAs - best-fit lookups were used to create BUASD values. Proportionate values were given to each GP’s prescription spending within a town based on what percentage of their inhabitants visited each practice. Figure 16 depicts the average monthly spend on Net Ingredient Cost for all antidepressant drugs in 2019. For more information please email the authors or find all our code used in constructing this dataset available at https://github.com/BenGoodair/Townscapes.
Local Impact of COVID-19

It will be some while before a full analysis of the impacts of the COVID-19 pandemic on communities is possible. In the early stages of the virus, no single geographical pattern across types of town is, as yet, apparent.

Our examination of death rate data supplied by ONS (2020) indicates that deaths from the virus are widely spread across towns of different geographies and deprivation levels. But data for the period between 1st March and 17th April does indicate that the most deprived towns have a slightly higher COVID-19 death rate than the most affluent (see Figure 17; ONS, 2020).

**Figure 17:** Recorded COVID-19 Related Deaths in the 100 Most, and Least, Deprived Towns.

![COVID Deaths in the Most and Least Deprived Towns](image)

**Figure 17.**
Source: ONS - Deaths involving COVID-19 by local area and deprivation; MHCLG - English Indices of Deprivation 2019 - LSOA Level
Figure 18 maps the worst affected towns in England for deaths from March to mid-April 2020.
Overview and Implications

Overall, our analysis suggests that there are some marked, and worsening, health inequalities within the English townscape. Its most deprived towns have worse health outcomes on a variety of important measures. Shorter life expectancy, worse self-reported health, and the higher relative incidence of a number of illnesses mean that people who live in these different places have much lower wellbeing than their counterparts in more affluent places. And these inequalities should be of concern to policy-makers across government – not just those focusing upon health. There is every chance that the ongoing coronavirus pandemic will make these inequities worse, not least because of its impact upon the employment prospects of those in the lower part of the income distribution.

One of the concrete implications of our analysis is the need for central and local
government to attend more seriously and systematically to the creation of healthier town environments, both in terms of access to green spaces and associated issues like air quality, but also in terms of the retail options available to residents. The debate about the changing face of the high streets of many towns needs to be informed by a greater awareness of the implications of town centres for public health. Local councils should consider using the licensing powers available to them to restrict the growth of outlets that sell convenience and fast food, and to keep them away from schools.

There is much to be learned by looking at examples of cities and towns that have made developing an infrastructure around green transport options, and also walking and cycling, a priority – including ‘pop-up bicycle lanes’ being introduced in towns and cities across Germany (BBC, 2020; Guardian, 2020). In many towns, there is a real imperative to focus upon reviving central areas in a way that is sustainable in environmental terms and reflective of the needs of particular communities – for instance those with larger proportions of older, retired people.

A separate policy implication of these findings is the imperative to provide more equitable access to the resources that enable better healthcare. The uneven prescription outcomes we have found, and the differential access to the kinds of spaces that promote better health, raise important questions about the kinds of environmental infrastructure in which poor health is promoted. Towns with better social and environmental infrastructures are likely to be better placed to help their populations cope with the challenges of the current lockdown, and any future lockdown periods.

The variable geography of health outcomes across English towns presents a considerable challenge for policy-makers, in part because of new demographic trends which are creating hotspots of deprivation among towns with an older age profile, from which younger residents tend to move to secure better opportunities. This is true of places like Blackpool and Aldridge (O’Connor, 2017; Centre for Towns, 2017). Coronavirus is likely to have a very profound impact on the health outcomes of towns with an above average proportion of the elderly. And it will also harm the employment opportunities and economies of a much larger group of relatively deprived places.

Our analysis also highlights some important regional concentrations of poor health, as well as large variations between towns in different parts of the country. We have noted, for instance, the poor outcomes in the West Midlands in relation to childhood obesity, and also the concentration of towns with high rates of hospital admissions for alcohol-related reasons in the North West, and the cluster of issues relating to these needs to be addressed by local government, metro mayors and the UK government too. But it is important to appreciate that there are
localised pockets of health deprivation – for instance the high rate of hospital admissions for intentional self-harm in Soham – which will require more tailored and specialist forms of intervention.

The current government’s commitment to ‘levelling up’ regions in England needs to be informed by an appreciation of the complex and geographically variable character of health inequalities. And these issues are intimately related to the challenges of boosting productivity and promoting inclusive growth. Tackling the factors damaging the health of some of England’s poorest towns will have a major impact upon the other policy goals which ‘levelling up’ involves – including boosting skill levels, promoting local employment and developing greater community resilience. In a period when the ethos and workers of the NHS are being given very public appreciation and support, it is important to remember too that the health of individuals and communities is determined by a much wider set of social, economic and environmental factors which lie beyond the walls of hospitals.
Key Findings from our Townscapes Health Survey:

- Towns, compared with cities, show a negative trend in health outcomes – changes to life expectancy have stalled or declined for many towns in recent years.

- The most deprived towns are much worse off than the least deprived towns on some key measures of health.

- The quality and accessibility of green spaces, and the nature of the local food economy, are closely linked to the health of local populations.

- Prescribing for some important medications does not appear to match levels of need in many places. Healthcare commissioners should look harder at how and why these patterns are at work in areas that they cover.

- The already large inequalities that exist between poor towns and other parts of the country will, without large-scale public policy interventions, only be made worse by coronavirus.

Image, above. Signs of support for the NHS