Health Equity in England: the Marmot Review Ten Years On

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Britain has lost a decade. And it shows. Health, as measured by life expectancy, has stopped improving and health inequalities are growing wider. Improvement in life expectancy, from the end of the 19th Century on, slowed dramatically, beginning in 2011. Now in parts of England, particularly among women in deprived communities and the North, life expectancy is falling, and the years people are spending in poor health may even be increasing – a shocking development. In the UK, as in other countries, we are used to health improving year on year. Bad as health is in England, in Scotland, Wales and Northern Ireland, the damage to the health of the country is nearly unprecedented.

Put simply, if health has stopped improving it is a sign that society has stopped improving. Evidence, assembled globally, shows that health is a good measure of social and economic progress. When a society is flourishing health tends to flourish. When a society has large social and economic inequalities there are large inequalities in health(1). The health of the population is not just a matter of how well the health service is funded and functions, important as that is, but health is closely linked with the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health(2).

This damage to the nation's health need not have happened. In 2010 there was concern both by the Labour government, and the Conservative-led Coalition government that followed it, that health inequalities in England were too wide and action to reduce them had to happen. To inform that action the Government in 2008 commissioned me to review what government and the wider society could do to reduce health inequalities. With colleagues at what later became the UCL Institute of Health Equity, we convened nine task groups of more than 80 experts to review the evidence and assembled a distinguished Commission to deliberate on that evidence. The result was the Marmot Review, *Fair Society Healthy Lives,* published in 2010(3). The Review was commissioned by the Labour Government and welcomed by the Coalition Government in a Public Health White Paper.

The Marmot Review laid out how public expenditure on policies, through the life course, could act on the social determinants of health to reduce health inequalities. The Review may have been welcomed in theory but in reality, under the banner of austerity, public expenditure was cut from 42% of national income in 2009-10, to 35% in 2018-19

In a new report, *Health Equity in England: the Marmot Review Ten Years On,* we show that austerity has taken its toll – in almost all of the areas identified by the Marmot Review as important for health inequalities – from rising child poverty and closing of children's centres, to declines in education funding, to a housing crisis and a rise in homelessness, to people with insufficient money to lead a healthy life and resort to food banks in large number, to left-behind communities with poor conditions and little reason for hope.

Given the strength of the evidence on social determinants of health inequalities, it is likely that this rolling back of the state had an adverse effect on health and health inequalities. I cannot say with any certainty which of the changes associated with austerity may have been responsible for the increase in health

inequalities, and which may cause damage in the future, but the figures reveal adverse impact across the whole range of domains in the Marmot Review on the lives people are able to lead.

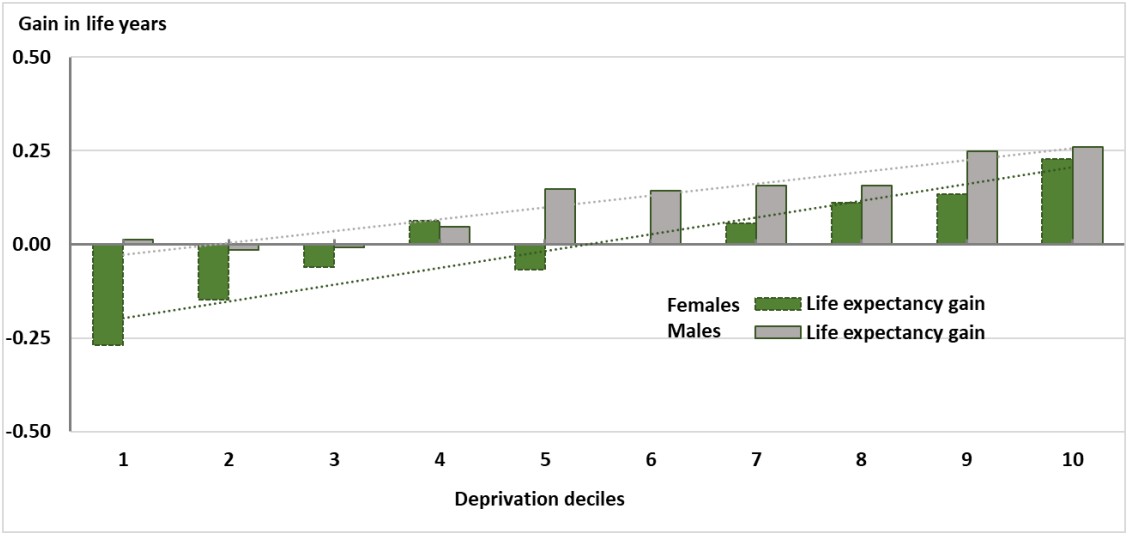
Inequalities in health – region and deprivation

The flattening of the upward curve of life expectancy was marked. From 1981 to 2010 life expectancy increased about one year every five and a half years among women, and about one year every four years among men. From 2011 to 2018 this slowed to one year every 28 years among women, and one year every 15 years among men.

The slowdown is real. It is the explanations that have been disputed. I claim, based on a general view of health trends globally, that if health stopped improving society must have stopped improving. There are more prosaic explanations that, having considered, we can reject. First: perhaps we've reached peak life expectancy. It has to slow some time. Plausible, but it is given the lie by comparison with other European countries. Countries with longer life expectancy than England, or other countries of the UK, continued to increase. We have a way to go before we hit peak. Second, perhaps we had bad winters and bad flu outbreaks. Mortality goes up in a bad winter. Analyses that we did for the Ten Years on Report showed that improvements in mortality slowed for non-winter months, as it did for winter months. At most, winter effects could account for between one sixth and one eighth of the slow down in improvement.

In support of my contention that the real causes of the failure of health to improve are social, are the growing inequalities in health according to deprivation and region. The relation between deprivation and health is graded. Classifying areas of the country by the index of multiple deprivation reveals a strong and consistent gradient: the more deprived the area, the lower the life expectancy, and healthy life expectancy – Figure 1 in the Marmot Review of 2010. The Figure here shows what has happened to the gradient in life expectancy. Inequality increased quite markedly – life expectancy is improving for the top 60%, not for the bottom 40%. More than that, for females in the bottom five deciles of deprivation, life expectancy declined.

Figure Gain in life expectancy by sex, England, 2012-14 to 2015-17



Source: based on PHE, 2019 (13).

There are well-known regional differences in mortality and life expectancy – sicker in the North. Deprivation and geography come together in important ways. For people living in districts in the least deprived decile, there is little regional difference in life expectancy. If you are among the most fortunate

ten per cent it doesn't much matter in which region of the country you make your home, and your demographic sub-group will have experienced improvement in life expectancy. The more deprived your district the greater the disadvantage of living in the North compared to London and the South East. Particularly for women, life expectancy in the most deprived ten percent declined in the North East, Yorkshire and Humberside and other areas outside London and the North West.

Life expectancy is used as an indicator, but health is more than expectation of length of life. The life expectancy figures apply to healthy life expectancy, only more so. The social gradient in healthy life expectancy is steeper than that of life expectancy. And years spent in poor health increased between 2009-11 and 2015-17: from 15.8 years to 16.2 in men; from 18.7 years to 19.4 years in women.

Cutting back in the role of the state may indeed have played an important part

The governments elected in Britain in 2010 and 2015 had austerity as a central plank of policy. The stated aim was to restore the economy to growth, by restricting public expenditure. By one measure, at least, it didn't work: wage growth. International comparisons of wage growth between 2007 and 2018 show that Britain, with minus 2%, was the third worst of 35 rich (OECD) countries, only beaten to bottom place by Mexico and Greece. ( )

If pushed, the governments would probably have denied that the purpose of policy was to make the poor poorer and allow the top 1% to resume the trajectory – briefly interrupted by the global financial crisis – of garnering a larger share of national income and wealth. That was, however, its effect. Changes to taxes and benefits introduced in 2015 were neatly regressive. The lower the income the greater the reduction in income as a result of changes to taxes and benefits. Cuts to services and to local government hit more deprived areas and families hardest.

In one sense, it is hardly surprising that if spending on welfare for families went down by more than 40%; if cuts to local government expenditure went down by 31% in the most deprived decile, compared to 16% in the least deprived decile; if funding for sixth form and further education fell by 12% per pupil; then there should be ill-effects. If the architects of these policies imagined that all that money had been going to waste, the evidence suggests that they were mistaken – our Ten Years On Report documents substantial harmful effects

Which of these might be most responsible for an increase in health inequalities is difficult to say because they are inter-related. In the Ten Years On Report we examine impacts in five of the six domains of recommendations made in the Marmot Review:

- Give every child the best start in life
- Education and lifelong learning
- Employment and working conditions
- Having enough money to lead a healthy life
- Sustainable places and communities

Here I highlight two, in addition to the cuts stated above: early childhood and housing.

<u>Giving every child the best start in life and continuing through the life course</u>

Investing in early childhood creates hope for the future. Adverse trends over the last decade will not be the explanation of the health trends of the last decade but may indeed be a harbinger of things to come. Early childhood is crucial; not just health of children, but level of development – cognitive, linguistic, social, emotional and behavioural development. Good early child development predicts good school performance, which in turn predicts better educational and occupational opportunities and more salutary living conditions in adulthood. Conversely, adverse child experiences (ACEs) cast a long shadow – predicting later life mental and physical illness.

More generally, both the good things that happen in early childhood, and the bad, influence individuals' abilities through the life course. We emphasise the importance of 'agency' – having control over one's life, empowerment – as central to health and health inequalities. Agency starts with good early child development and protection from ACEs. It continues with having enough resources in adulthood to lead a life that one has reason to value. Having insufficient money to pay rent or feed children is deeply disempowering.

Early childhood contributes to health inequalities in adult life because of the social gradient. Good early child development is less common with increasing deprivation and adverse child experiences are more common.

Therefore, two approach to reducing inequalities in health must be to improve services that break the link between deprivation and poor outcomes for children *and* to reduce deprivation in childhood. The signs are not good. It has been estimated that, as a result of cuts to local government, 1000 Sure Start Centres have had to close. The welcome support for child care for older pre-school children does not make up for these closures.

A much-used measure of child poverty is the per cent of children living in households at less than 60% median income. In 2009-12, child poverty was 18%, rising to 20% in 2015-18. But the cost of housing can drive people into poverty. After housing costs are taken into account, child poverty rose from 28% in 2009-12 to 31%.

Shortage of housing contributes to increased costs. The proportion of people paying more than a third of their income on housing costs, unsurprisingly, follows the social gradient, but has risen in all income groups. In the lowest decile of income in 2016/7, 38% of families were paying more than a third of their income in housing, up from 28% a decade earlier.

Time for action

In the Marmot Review in 2010, we wrote: *health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society.*

A report from the Royal Society for Public Health suggested we got the evidence and approach more or less right. RSPH surveyed their members and a panel of experts on their views on the major UK public health achievements of the 21st Century to date. The top three were the smoking ban, the sugar levy, and the Marmot Review.

We have now laid out a new set of recommendations following the intellectual framework of the Marmot Review. It is our firm view that such recommendations are vital to creating a society that is just, and sustainable for the current and future generations.

1. Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organisation; 2008.

2. Marmot M. The Health Gap. London: Bloomsbury; 2015.

3. Marmot M. Fair society, healthy lives : the Marmot review ; strategic review of health inequalities in England post-2010: [S.l.] : The Marmot Review; 2010.