

INTERVIEW



Professor Sir Michael Marmot

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Tackling Social Determinants Of Health Around The Globe

A global health equity movement relies on research showing how social factors affect health.

BY ALAN R. WEIL

Social determinants of health—factors such as housing, education, neighborhood, and income—have increasingly entered health policy conversations as a growing body of research reveals the direct relationship between these so-called social determinants and health outcomes. Professor Sir Michael Marmot was an early proponent of shifting from the traditional model that focused on how

health affects economic status to a new view that economic status affects health.

A renowned thinker, leader, author, and researcher on health equity in England and across the world, Marmot has led research groups on health inequalities for more than forty years. His work at the World Health Organization as chair of the Commission on Social Determinants of Health and on the report *Closing the Gap in a Generation* (2008) led health officials in England

to ask him to apply these findings to their own country. The result was *Fair Society, Healthy Lives* (2010), also known as the Marmot Review.

The Marmot Review concluded with six policy objectives where action was needed to achieve health equity. Cities and regions around the world have followed this blueprint, with some, such as Manchester, England, adopting the moniker of a Marmot City. Marmot recently completed a retrospective review of progress in England toward the Marmot Review's policy objectives. That report, *Health Equity in England: The Marmot Review 10 Years On* (2020), reveals areas of progress but shows that much work remains.

In 2019 Marmot brought his framework to the Americas in the report *Just Societies: Health Equity and Dignified Lives—Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas*. This more recent effort includes perspectives on indigenous populations, gender and sexual identity, and migrant populations while also exploring emerging environmental threats such as climate change.

Spanning the globe while also reaching into cities and neighborhoods, Marmot's contributions to the field of health equity have changed lives, policies, and the outlook for people around the world. Alan Weil, Health Affairs Editor-In-Chief, sat down with Marmot on April 28, 2020, to discuss his work and recent events. What follows is an edited transcript. The full interview can be heard at <http://www.healthaffairs.org/podcasts>.

ALAN WEIL: Let me start by having you take us back to 2010, to the original Marmot Review [*Fair Society, Healthy Lives*]. Your charge was to focus on health inequality in England. You took on social inequality more broadly as the dominant determinant of health. That was a bold choice. I wonder if you could say a little about what led you to take a social determinants approach when your charge was to focus on health inequality?

SIR MICHAEL MARMOT: Well, I had chaired the WHO [World Health Organization]

Commission on Social Determinants of Health. And so you might say that the bold decision was there, going to the WHO, and suggesting to the director general that he should set up a commission on social determinants of health.

At the time, and in some quarters still, the discussion about economics and health was that the direction went from health to economics. In other words, it was your health that determined your income or the health of nations that determined the economic performance of nations. I was convinced from my own research that there was an important pathway that went the other way, and we should say that. I went to J. W. Lee, who was the newly elected director general of the WHO, and suggested we set up a Commission on Social Determinants of Health to say that there is a causal pathway from social and economic conditions to health.

My view was that health was a better goal than economic performance: Even though the pathway may go in both directions, which was the more important goal? Well, I had no doubt at all! I'm a doctor. I didn't study medicine so that I could help contribute to a bigger economy. I studied medicine because I wanted to help people be healthy, and I went into public health because I wanted to help populations be healthy. So that was, in my view, a far more important goal.

Then the British government said, "You produced this global report; how could we apply the conclusions and recommendations of your global commission to one country, England? Could you do a commission for us?" I accepted that challenge, and we set up a high-level panel of commissioners. We set up nine task groups to review the evidence tailored to a rich country, and a specific rich country: England.

The charge was to look at, as we called it in the UK, health inequalities. That meant much more than inequalities in the health care system, it meant the conditions that made people sick, which means the social determinants of health. How could we use the evidence to make the case for what needed to happen on the social determinants of health in order to improve health and reduce inequalities?

We had six domains of recommenda-

tions: early child development; education and lifelong learning; employment and working conditions; having enough money to live on, to lead a healthy life; healthy and sustainable places in which to live and work; and taking a social determinants approach to prevention—so-called lifestyle.

None of the six domains had to do with the health care system—not because I thought that the health care system was unimportant, but because everybody was looking at the health care system. That's what people do when you say health: everyone immediately jumps to the health care system.

Social Gradient

WEIL: One element of the original Marmot Review is this notion of a gradient. Equity isn't just about lifting up the poorest or the bottom, but it's the entire spectrum of disadvantage. Could you talk a little more about the evidence base for that and what the implications are?

MARMOT: Well, there aren't many people who could say this, but the British Civil Service changed my life. Civil servants exclude the poorest people in society, and they exclude the richest. But they certainly know about hierarchies, and [in the Whitehall Study of the British Civil Service] we saw this amazing hierarchy in health and in mortality rates by grade of employment. By definition, everyone was employed; they were largely white, we had very few immigrants, and no women. It excluded a lot of the kind of normal variations, and yet we had this remarkable social gradient.

Of course, this phenomenon was not confined to civil servants. When we were then able to look at national figures, there it was, this remarkable gradient for the country for local areas and neighborhoods, classified by the index of multiple deprivation. Life expectancy runs in a graded way all the way from top to bottom, and there's an even steeper gradient for disability-free life expectancy.

In my 2010 Marmot Review, I coined the rather unfortunate term "proportionate universalism," a classic British compromise. The default position of social policy in Britain, as in the United States, is to target, to means-test. You don't get certain benefits unless you're below some threshold. Well, the problem with that is it misses the gradient. It

seems to me that we want universalist policies that apply to everybody. Rather than say: "We'll have this service for problem families," say: "We'll have this service for everybody, but with effort proportionate to need." That was the idea of proportionate universalism. It was trying to combine the common-sense benefits of targeting with the universalist approach that would deal with the gradient.

Austerity And Inequality

WEIL: So, here you have a vision, proportionate universalism, that's designed to be progressive. But one of the findings in the 2020 Marmot Review ten years later [Health Equity in England: The Marmot Review 10 Years On] is that Britain went through a period of retrenchment, and government investments actually became more regressive.

MARMOT: If you classify local authorities into quintiles by deprivation, policies over the past ten years were neatly regressive. The more deprived the area in which the local authority is located, the steeper the reduction in spending by local government. In the poorest 20 percent, there was a 32 percent reduction in per capita spending, and in the richest, the least deprived 20 percent, it was 16 percent.

Two characteristics of austerity were implemented in 2010: one, rolling back of the state, and two, having regressive social and economic policies. You can't get away with it and think you're not causing damage. You may have had the aim of reducing the national debt and the annual deficit. But you can't do it and think there are no ill effects.

My *10 Years On* review showed a very clear change in the curve of improvement of life expectancy. The rate of increase of life expectancy slowed dramatically and, in fact, just about ground to a halt. The inequalities in life expectancy increased by deprivation and by region. And life expectancy of the poorest women, particularly outside London, went down. So, we have at least three phenomena: stalling life expectancy, increasing inequalities, and actually a decline in life expectancy for the poorest women outside London.

I've shown that most social and economic policies became more constrained and more regressive over the

ten years, and health inequalities got worse. I can't say the one caused the other. It is not an experiment. But it's highly likely that austerity and erosion of these social and economic conditions contributed to the health picture that we see.

Role Of Geography

WEIL: In your work you focus on the role of geography and the geographic unit. Could you expand on the role of geography and community and neighborhood and how your thinking about that role has evolved?

MARMOT: It's a very interesting question. I think about geography in different ways. One is, it's a proxy for individual characteristics. We can get data on deprivation by area much more quickly than we can by characteristics of individuals. So, on one level I think of geography as a proxy for the individual.

Then there is the second way to think about it. My colleague, Peter Goldblatt, when he was at the Office of National Statistics, showed years ago in the UK—and Raj Chetty a few years later published similar data for the US—this very interesting interaction. If you look at people of the highest socioeconomic level, there's no regional difference within the UK in life expectancy or mortality. If you're at the top level, it doesn't matter where you live. You can live in depressed Newcastle-upon-Tyne or you can live in opulent London, and it doesn't make any difference. The lower you are in the social hierarchy, the more the region matters. And that's really interesting.

Now you could say region is a proxy for the individual, but it's capturing something that the national socioeconomic classification based on occupation is not capturing. So, being a shop worker or a deliveryman and living in the North East, life is harder than being a shop worker or deliveryman and living in the South East of the country. And you could translate it into individual characteristics.

Or you could ask, What is it about the North East that's different from the South East? It may relate to economic opportunities. It may relate to social conditions. It could be historical geography. I mean, it could relate to the decline of manufacturing in the North, whereas there was decline in manufacturing in the South East, but there was

also the rise of the service sector, the very vibrant City of London and financial sector, in a race with New York to be the financial capital of the world, with all of the trickle-down in industry and employment that there is. So, one could think about geography as telling us something more about the lives of individuals, but also telling us something about place.

And then the third way I think about place is it's a locus for action. We've talked about the fact that things went pretty poorly in terms of national action between 2010 and 2019. The only locus where there was encouragement was at the city level. So, the city of Coventry became a Marmot City. We're working with Greater Manchester. They declared themselves a Marmot Region. We're working with Gateshead, which is the city just across the river from Newcastle, on the Chester-le-Street side, so they've taken a Marmot approach to doing things at the city level.

If I ask myself, Which is more important, the national or the city level, the answer is, They're both important. The national level sets fiscal policy, for example. Child poverty is very much affected by national policy. But there's good reason for applauding action at the city level, not just because, well, if we can't get national action, let's get city action. But that is where people live and work. It is an appropriate locus of action.

Cross-National Perspective

WEIL: You recently completed the Pan American Health Organization (PAHO) commission report [*Just Societies: Health Equity and Dignified Lives*]. Could you reflect on the additional challenges associated with analyzing these issues from a cross-national perspective?

MARMOT: Unlike the answer I gave you at the beginning of our conversation, we included health systems in the PAHO commission report because it's important. In the UK, we have the National Health Service, which lots of people study. We have a high degree of equity of access. That's not true when you go to the countries of the Americas. They have huge inequalities between countries and within countries. So, they are twin challenges.

In some of the South American, Latin American countries, there's a strong tra-

dition of social medicine that was active in the fight against military dictatorship. We needed to try and learn from that strong tradition in Argentina and Brazil and other countries, such as Chile, where they've been very active. They'd fought and died for their beliefs. There was a very good tradition on which we could draw, and also huge inequalities.

And there were also some particular challenges that we focused on. The health of indigenous versus nonindigenous peoples throughout the Americas united our commissioners from Canada, the United States, and the rest of the region.

Related to that, for people of African descent throughout the Americas—again, a huge issue of disadvantage. We talked about structural racism quite overtly. And we also were more explicit about gender. We certainly talked about sexual orientation and people with and without disability. So, we drew attention to several of these issues.

One thing that we did more explicitly than I'd done in my previous three reports (the global commission, the English one, and the European Review), we were much more explicit about human rights both as a value and as a mechanism—the value of respecting human rights, but also a mechanism for taking action.

We also wanted evidence from the region of what you could do, because it might be that you could adapt what was going on in the Italian city of Trieste to La Paz or Guayaquil or Rio de Janeiro. But it might be that you couldn't very well. What's going on in Trieste is very impressive, but it's got this Austro-Hungarian tradition mixed with Italian. We wanted examples of what you could do in the [American] region.

COVID-19

WEIL: I do want to reserve a few minutes to talk about the current COVID-19 pandemic. I'm curious how your reaction to the pandemic is shaped by your work. And I'm also curious about how the pandemic shapes your views of your own work.

MARMOT: My view is that the COVID-19 pandemic and the societal response to the pandemic expose and amplify preexisting problems. I know the figures from Britain better, but I'm reading pieces in

the *New York Times* that are more or less saying word for word what I've been saying about Britain.

Look at working from home: If you look at deciles of income, the lower your income, the less likely you are to be employed in an occupation where working from home is a possibility. So, professors can work from home, but workers in the hospitality industry can't. Hotels have closed, restaurants and cafes and pubs and bars have closed. Those workers are either unemployed or, if they're furloughed with 80 percent of their salary [as is the case in the UK], their income has dropped.

Something like a third of household income is spent on entertainment, dining out, and things of that nature. Well, of course, the richer the household, the more likely they are to dine out and go to restaurants and opera and even football. I mean, football tickets are so expensive, and it's become something for the rich to enjoy. The poor people who worked in those industries are either unemployed or had a drop in income, and the people who are spending money in those industries are spending less, so they actually have more money.

Look at shelter. The same people who can work from home, probably, if they have an aging grandparent, can say, "Well, you use a separate bathroom." I was talking to a journalist, and we were talking about a nurse living in a one-bedroom flat with two children and a husband. She comes home from a day in the wards and she's trying somehow to get her clothes off and have a shower before she hugs her children so she can be clean. But that's hard to do when you're in a one-bedroom flat with a tiny bathroom.

So child poverty, education, work, income, and living conditions will all be made worse by the pandemic and the societal response to the pandemic.

Then the question is, What happens next? In 2009, the year after the global financial crisis, the global economy shrank by 0.1 percent, according to the International Monetary Fund. Now the IMF estimates that the effect of COVID-19 on the global economy is thirty times bigger than the global financial crisis

of 2008. And I think they've underestimated.

Do you remember the Grenfell Tower fire, the high-rise housing block in London that went up in flames three years ago, and seventy-two people died? It was terrible, huge, terrible. You could think about that fire in two ways: One is it exposed the underlying problems in society, and the second is it told us that we need to do things differently. The underlying problem that it exposed was that if you look at the electoral ward adjacent to Grenfell Tower and the rich bit of the borough where Harrods is, the life expectancy gap for men is twenty-two years. Yes, the Grenfell Tower fire was a terrible tragedy, but what about the slow-burning injustice of that twenty-two-year gap in life expectancy between the poor area and the rich area within the same London borough?

Faced with the catastrophe, the conflagration, everybody—politicians of all stripes—said, "Oh, gosh, we've got to do something." But what did they do about the underlying inequalities? They imposed austerity, made them worse, and fanned the flames of injustice.

So, coming back to COVID-19. We've got this pandemic, that's a conflagration. What did the government do in Britain? They said, "We'll spend whatever it takes." The same political party that in 2010 presented debt reduction as a moral imperative, something where there was no alternative, now they're saying, "Debt, forget it, whatever it takes." Well, if they can do that for the conflagration, they should do that for the slow-burning injustice of persisting health inequalities. And the message of my *10 Years On* report is: Whatever you do, don't come out of this pandemic saying, "Ah, now we've got to impose austerity." We have to do things differently as we emerge from the pandemic.

Evidence Of Progress

WEIL: I was hoping we could end with some positives. What do you see that encourages you?

MARMOT: If I showed you my diary (before COVID-19 hit), you would see that these ideas are taking off—people are concerned about it. We set up an Insti-

tute of Health Equity in Hong Kong. I was planning to go to Hong Kong, Japan, and South Korea to work on a network that we want to develop on social determinants and health equity. We were planning a meeting in Canada to promote uptake of the PAHO commission report. I was planning to go to Argentina and Brazil, and I've been invited to Colombia. I'm chairing a commission on the social determinants of health for the Eastern Mediterranean region of the WHO, the largely Muslim countries of that part of the world. And we've got lots of European activity. I can't get to Australia as often as they invite me.

These ideas are taking off. And I'm delighted by that. There's progress. We said at the beginning of the WHO Commission on Social Determinants of Health we wanted to create a social movement for health equity and social determinants. And I think we've been doing that. That's what my diary is telling us, in every region of the world.

What's behind it is two things. One is an increase in knowledge. We know a lot more than we did. And that comes from people working hard all over the world to produce the evidence. The second is a commitment to social justice and health. It's both of those—it's the evidence that people are compiling that we can make a difference and the wanting to make a difference because it's the right thing to do, that is hugely encouraging.

We have to recapture that as we emerge from the pandemic.

WEIL: It's been a wonderful conversation. I am grateful to you for taking the time to talk to me. ■

Professor Sir Michael Marmot is a professor of epidemiology at University College London and director of the University College London Institute of Health Equity, both in the United Kingdom, and past president of the World Medical Association.

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