# A programme for greater health equity for the next UK Government

The UK is unhealthy, literally and metaphorically. Literally, since 2010, many health indicators have stopped improving, health inequalities are increasing between social groups and regions, and health for people who live in the most deprived areas is declining.[1–4] Metaphorically, because the state of health of a population reflects how well that society is meeting population needs. The implication is that British society has stopped improving, inequalities are increasing, and social conditions for the poorest people are getting worse.

In our view policies to address this poor state of society and improve health equity should be a central topic for the UK election that will take place on July 4, 2024. If the first weeks of campaigning are anything to go by there seems to be general avoidance of this central topic, or dissembling about the substantial cuts to the social and economic fabric of society which have harmed health.[1-4] Greater honesty is needed about what has driven the poor state of health in the UK and greater clarity is needed about strategies for positive action.

Statements about the economy illustrate our call for honesty. The current UK Prime Minister Rishi Sunak and the Chancellor of the Exchequer Jeremy Hunt, on the basis of gross domestic product (GDP) growth in the first quarter of 2024, said that the tough decisions they took have turned the economy around and that the UK now has the fastest growing economy in the G7.[5] The non-partisan House of Commons Library published its own assessment of the GDP data.[6] UK GDP in the first quarter of 2024 was 1·7% higher than pre-pandemic levels in the last quarter of 2019.[6] That was the second slowest growth of the G7 countries; only Germany was slower.[6] Predictions for 2024 by the International Monetary Fund and the Organisation for Economic Co-operation and Development (OECD) again show the UK to have the slowest predicted growth of all the G7 countries, except Germany.[6] Surely, to put things right, it is necessary to recognise what has gone wrong.

Much of what went wrong with respect to the social determinants of health equity in the period after 2010 comes under the rubric of austerity, imposed by a Conservative Party led coalition Government. In the 2020 Marmot Review,[1] we reported that in 2010 public sector expenditure had been 42% of GDP. Over the next decade, public sector expenditure went down year on year. By the end of the decade, public sector expenditure had become 35% of GDP.[1] An annual reduction of 7% is enormous. In 2023, total UK GDP was £2·687 trillion.[7] 7% of that is £188 billion. At today's prices, annual public sector expenditure in 2019 was £188 billion less than it was in 2010. It is then not a surprise that relative child poverty went up— the steepest rise among 39 OECD countries;[8] absolute measures of destitution increased; welfare payments apart from pensions did not keep pace with inflation; spending on education per pupil went down; the housing shortage became more marked and homelessness and rough sleeping increased; and increases in health-care expenditure fell sharply compared with historic trends.[1,9] Alongside these major changes, came the slowest improvement in life expectancy in the UK during the decade after 2010, of any rich country except Iceland and the USA.[1]

The cuts to public sector expenditure were regressive. In a 2024 Institute of Health Equity report, we plotted male and female life expectancy of each local authority in England in 2010–12, and showed that the shorter the life expectancy the steeper were the subsequent cuts in local authority spending power by 2019–20.[3] It was as if, the greater the need for investment, the greater was the withdrawal of funds.[3] It is highly likely that the cuts to public sector expenditure since 2010 have contributed to slower health improvements, increases in health inequalities, and declines in health in the most deprived areas.[1] Much of our analyses have used life expectancy or mortality rates. Levels of reported ill-health have also been rising in the most deprived areas.[1] There is an intersection between deprivation and geography. Using the index of multiple deprivation for small areas, we see a gradient—the more deprived the area the higher the mortality rate. That gradient is steeper in the northeast and northwest of England than it is in London; the regional disadvantage for people in the most deprived areas increased after 2010.[1,3]

We propose immediate, medium-term, and longer-term recommendations for greater health equity in the UK, but emphasise that the time to start on the

longer-term recommendations is the day after the election.

The immediate recommendation is to put equity of health and wellbeing at the heart of all government policies. Had that been done in 2010, regressive policies of austerity simply would not have been pursued. Of course, the National Health Service (NHS) should be properly funded, but attention to the social determinants of health is vital. The principle of proportionate universalism should be applied to all policies aimed at reducing inequalities.[10] Health follows a social gradient—the greater the deprivation of an area the higher the mortality rate and the worse the health.[10] A policy of targeting only the people who are worst off misses people with social disadvantage and related health disadvantage who fall above the threshold of intervention. We recommend universalist policies with effort proportionate to need. The NHS is an embodiment of proportionate universalism, with need defined clinically. We would apply universalism to the social determinants of health with need defined socially.

Our medium-term recommendations are to build on the knowledge of how the conditions of daily life influence health inequalities.[4,11,12] Our Institute of Health Equity is in active collaboration with local authorities, voluntary organisations, health and care services, and businesses to reduce health inequalities. Over 40 places in England, Wales, and Scotland have prioritised health equity, developed systems to deliver it, and applied eight health equity principles (panel)[8], styling themselves Marmot Places.[13–15] Along similar lines, WHO has a Special Initiative aiming to reduce health inequities through action on the social determinants of health, ongoing in nine countries, funded by the Swiss Agency for Development and Cooperation. This initiative is applying knowledge on the social determinants of health in practical programmes to reduce health inequalities.[16]

One obvious question with any of our recommendations is the cost. The budget cuts to the areas where we have been working to develop Marmot Places have been severe: central government funding to local authorities was reduced by 59% over the decade from 2010.[3] That has not stopped local authorities, the voluntary and community sector, health and care, and business working together to act on the social determinants of health to create conditions for greater health equity.[15] At the national level too these sectors are increasingly orienting towards improving health equity. The Institute of Health Equity has established strong partnerships with large businesses, voluntary sector organisations, and the NHS to act on the social determinants of health. For example, we proposed three domains of action for business: pay and conditions for employees; quality of goods and services in so far as they influence health; and wider impact on communities and environment.[17] NHS health-care trusts are working to apply similar principles.[18] It is encouraging that such efforts are under way even in the bleak national context in which public sector expenditure has been cut in regressive fashion.

Our longer-term recommendation is nothing less than the transformation of society. 40 years of neoliberalism, with some interruptions, have degraded the public realm, which is crucial, along with a thriving private sector, to creating a society where all can flourish and health inequalities can be addressed. Furthermore, the neoliberal model has led to marked concentrations of income and wealth. A geographical analysis of GDP per person in the UK showed that without the richest region, London, UK GDP per person would be 14% lower and as low as Mississippi, the poorest state in the USA.[19] The UK is a poor country with a few rich people.

Levelling up—policies to reduce regional social and economic inequalities—was a worthy aim.[20] It is a pity it was not pursued. As described above, the consequences of deprivation for health are greater in the northeast and northwest of England than they are in London and the southeast.[3,10] The long-term aim of a new UK Government must be a real commitment to polices that address regional socioeconomic inequalities and improve health equity across the UK.

***Panel:*** **Eight principles to prioritise health equity**

- 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
- Strengthen the role and impact of ill-health prevention
- Tackle racism and discrimination and their outcomes
- Pursue environmental sustainability and health equity together

These Marmot Principles are from the 2010 report *Fair Society, Healthy Lives: the Marmot Review.*[10]

Based on our experience with Marmot Places and collaborating organisations we are convinced that this is a realistic agenda, both because of the commitment of the professionals and communities who are working to improve the conditions in which people are born, grow, live, work, and age—the social determinants of health—and because our recommendations (panel) are pragmatic, feasible, and, while benefiting from public investment, will not break commitments to fiscal constraint and will support a healthier, more productive workforce.

The two main political parties in the UK are vying with each other as to which can display the most rigorous fiscal discipline. We would rather see a debate as to how to rebuild the country, along the lines we propose, that would improve health and reduce health inequalities. We venture to suggest that our proposals are relevant to all countries. Our more general point that is fundamental is, to quote Raymond Williams: "to be truly radical is to make hope possible rather than despair convincing".[21]

We are both involved in programmes to develop Marmot Places and are Director (MM) and Deputy Director (JA) of the Institute of Health Equity (IHE) that is working with collaborators on Marmot Places. Funding for IHE comes from University College London and the places that commission us to advise them. IHE is one of the academic centres collaborating in the WHO Special Initiative. We declare no other competing interests.

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