Marmot Review Working Committee 3
Cross-cutting sub-group report

Learning Lessons from the Past: Shaping a Different Future
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Introduction

Building on his role as Chair of the WHO Commission of the Social Determinants of Health, Sir Michael Marmot has been asked by the UK Government to review the latest evidence in health inequalities in England with a view to informing policy post-2010. The review is considering a wide range of issues and has been supported by a number of task groups reviewing evidence, and working groups considering issues of implementation and indicators/monitoring progress. In this paper we consider various sources of evidence including personal experience of the policy process to identify some lessons learnt from the past which should inform the Commission's deliberations as it moves into the final stages of its work. In particular, we attempt to distil lessons about why better progress has not been made to date in reducing health inequalities and identify clear messages about how a difference might be made in the future.

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Why has better progress not been made to date in reducing health inequalities?
For many people there is a real sense of déjà vu in addressing this topic. There has been no shortage of political and intellectual energy invested in understanding the causes and effects of health inequalities in recent years – the problem has been amply described. However, progress on significantly reducing these inequalities has been limited. In an attempt to elucidate why this is the case, we have examined four key issues: delivery mechanisms; 'lifestyle drift'; how policy is handled within Government; and power, knowledge and influence.

(i) Delivery mechanisms
The model for change and delivery at local level in public services, including the NHS, over at least the past decade has been based on an essentially mechanistic and reductionist model of rational linear change, driven from the centre. Regardless of the extent to which policy-makers seek to embrace notions of complexity and adaptive systems thinking, the processes

and structures adopted in practice remain rooted in a model and approach which has yet to make a significant impact in reducing health inequalities and, in fact, seems unlikely ever to do so. Evidence for this is available in the academic literature and is also considered in the Cabinet Office's Capability Review of the Department of Health conducted in 2007. The review was critical of the Department's absence of strategy and its tendency to impose policy on the NHS and other agencies without seeking views or support for it from frontline staff and the public. It was also critical of the Department's fixation on the NHS to the exclusion of other determinants of health. A follow up capability review, published in July 2009, concluded that although much progress has been made, 'improvements made are not yet sufficiently embedded' and there remains incoherence around, and a need to clarify, the Department's 'strategic narrative for achieving better health and wellbeing'. In short, a sustained focus is required on clarity of purpose and the delivery mechanisms. We believe that a fundamental shift is required away from centrally driven, target-focused approaches and towards new systems-based approaches, locally-owned, which recognise the inter-relationships between the determinants of health inequalities and focus on fundamental causes. These require the support of long-term Government strategies for addressing health inequalities (as opposed to short-term wins, and approaches that can be managed through well-established vertically organised sector-based performance management structures). They also require a priority to be placed on workforce capacity-development to support new ways of working. Whilst such approaches do not usually make headline news, we believe that without changes in *the way* people work, the types of leadership they are given, and the relationships they have to different sectors and the communities they work in, the impact of *what* they do – even if they are doing different things – will be insufficient.

An example of past failure to reduce inequalities in health is well documented in the Government Office for Science's Foresight report on obesity published in 2007. It concluded that we live in an 'obesogenic environment' which means that simple solutions like targeting obese individuals and encouraging them to eat less, more healthily and to take exercise, is only a small part of the solution. The key message is that there is no single or simple solution: the problem is complex and multi-faceted and requires an ecological approach to change. Solving such a problem demands far more than the government's response to the Foresight report has offered to date through Change4Life and other initiatives that have centred on individual lifestyle and behaviour change. In focusing on these, it has entirely missed the point of the Foresight report's whole systems analysis and conclusions calling for action on a range of fronts and at different levels. Reports on social determinants of health, likewise, consistently highlight the need for cross-cutting action – both within and across government and at local levels – and for recognition of the inter-relatedness of the factors that lead to health inequalities (power relationships, poverty, employment conditions,

environmental quality etc). If the response is once again narrow and focused on lifestyle, the outcome will once again be a failure to impact significantly on inequality.

(ii) 'Lifestyle Drift'

The government's response to the Foresight obesity report is an example of 'lifestyle drift,' by which we mean the tendency for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors. Coupled with this is a drift away from recognition of the social gradient towards plans for action that target the most disadvantaged. Over the past 10 years, the drift towards a focus on lifestyle and 'excluded groups' has become a familiar feature of major UK initiatives, though it is in no way confined to this country: the same tendency can be seen in other European countries and in WHO policy documents.

In the UK such initiatives include: the national public health strategy in its evolution from *Saving Lives* (1999) to *Choosing Health* (2004); the Treasury cross-cutting review on health inequalities (2002); *Tackling health inequalities: a programme for action* (2003); the report from the House of Commons Select Committee on Health Inequalities (2009), and the Secretary of State's review *Health inequalities: progress and next steps* (2009). One of the most striking examples of lifestyle drift can be seen in the Treasury cross-cutting review, set up in 2001 to map what the many government departments, NHS and local authorities were doing at the time to tackle health inequalities, "to consider how better to match existing resources to health need and to draw up a long-term strategy to narrow the health gap"(p.2, HM Treasury, 2002). All government departments, excluding the Treasury, were asked to submit evidence on their then current contributions to tackling health inequalities. The final report recognised the wider social determinants of health and the existence of the social gradient but when it came to recommended actions, there was a heavy emphasis on individual lifestyle issues in disadvantaged areas and groups. This is clearly reflected in the short-term "top priorities" for meeting the 2010 health inequalities targets, which were, for the life expectancy target:

> "reducing smoking, prevention and effective management of risk factors in primary care (e.g. through early identification and intervention... through lifestyle and therapeutic interventions, including statins and anti-hypertensives according to need); environmental improvements to improve housing quality to tackle cold and damp and increase safety at home (e.g. smoke alarms, hand rails)...; and targeting over-50s where the greatest short-term impact on life expectancy will be made." (Treasury, 2002, p.4)

For the infant mortality target and on early years development, the high impact interventions were judged to be:

> "building on Sure Start to improve early years support in disadvantaged areas; reducing smoking in pregnancy; preventing teenage pregnancy, and tackling its causes and effects; improvements in housing conditions for children in disadvantaged areas; and other forms of early intervention for the NHS (e.g. increase immunisation rates and breastfeeding, improve diet, family support and education about infant sleeping position)." (Treasury, 2002, p.4)

The long-term strategy developed by the cross-cutting review likewise had a broad rhetoric, but when it selected key themes from the analysis of evidence, the drift began. The titles of the themes are: "breaking the cycle of inequalities; tackling the major killers; improving access to public services and facilities; strengthening disadvantaged communities; supporting targeted interventions for specific groups [in the most disadvantaged circumstances] ("e.g. vulnerable older people, vulnerable members of black and minority ethnic communities, the fuel poor, rough sleepers, prisoners and their families, refugees and asylum seekers, looked after children"). While there are still examples of recommendations for tackling wider determinants such as child poverty and low educational attainment, the drift is evident.

The report of the House of Commons Health Committee, published in March 2009, is a more recent example of lifestyle drift in health inequalities. Although it had a restricted remit - what the NHS and Department of Health have done, and could do further, to tackle inequalities in health – nevertheless, the first half (defining the problem), is quite broad and wide-ranging. It concludes that "the causes of health inequalities are complex, and include lifestyle factors – smoking, nutrition, exercise to name a few – and also wider determinants such as poverty, housing and education". However, when it comes to action, the Committee offers a patchwork of recommendations. Some, such as the ones on early years and Sure Start, are consistent with the problem analysis, while others are not. The most strongly expressed and "urgent" recommendation was immediate legislation to introduce a statutory traffic light labelling system for foods. Important though that may be, lack of information on food labels is arguably not a major cause of the observed inequalities in health in the UK. Health promotion in schools, cleaning up the built environment and tobacco control were further recommended action areas in sectors outside the health sector to promote "measures to enable people to adopt healthier lifestyles". (The Appendix attached to this paper raises similar issues specific to the current Marmot review report, with regard to the potential for lifestyle drift.)

The Health Committee report is also noteworthy for making an issue of "lack of evidence and poor evaluation", claiming that "it is nearly impossible to know what to do given the scarcity of good evidence and good evaluation of current policy". Chapter 3 is devoted to a critique of the lack of impact evaluation, followed by detailed recommendations on evaluation research

design, dismissing qualitative research as "soft" and "amounting to little more than examining processes and asking those involved what they thought about them" (para 75, p. 38). The Committee comes down heavily in favour of experimental or quasi-experimental research designs for all new policy initiatives. As discrete, downstream, projects are more amenable to this kind of research design, it steers the research effort towards the more obvious lifestyle projects. Whilst recognising the scientific weight that comes with experimental designs, we recommend that the Marmot review should challenge the over-emphasis placed on these study designs by the Health Committee, and balance it with a recognition of the importance of research into the processes of delivery, the experiences and views of those with the worst health in the UK, and the consequences of actions taken in one part of the system on other parts of that system (which adopting a systems approach would allow for).

(iii) How policy is handled within Government

A third set of issues relate to how policy is handled within Government. There are many potential pitfalls in the way of a sound policy (in this case one which is focused up-stream, is clear about addressing the gradient in health as well as discriminating positively towards specific groups, is cross-cutting and long-term) being translated into an action plan commensurate with those policy aspirations – even before the issues highlighted above about local delivery come into play.

From personal experience within our group, as well as insights gleaned from others' reviews of past policy, we would highlight the following issues for careful consideration as the current process proceeds:

- Although a team of officials is usually identified to lead the work, many more people get involved and pursue the special interests of their part of the organisation. Those leading the process need to be careful custodians of the integrity of the policy, and not allow it to be skewed by special interests, strongly expressed.

- Representatives of other government departments may only have a partial view of how the policy recommendations affect their department's work (as very few officials have a full overview of their department's scope). This can again lead to skewing, but also to missed opportunities.

- Management of competing initiative-based lobbying will be necessary to ensure that the most important issues are taken forward, not those advocated by people who shout loudest or have the most time.

- The presentation of the report can become more the focus than the content. Linked to this, what is included within the public summary (and media release) is likely to become the dominant agenda for implementation, as it represents a public commitment. Once again, there is therefore potential for a comprehensive policy to be salami-sliced, and discrete quick-wins to be prioritised.

Issues of political palatability, public receptiveness to messages about societal change and inequity, future-proofing, and management of vested interests outside government are also among the hurdles to be jumped. However, these are perhaps more often discussed/made explicit, than those listed above – which in our view are within the scope of government to manage and should be addressed as the current process proceeds. We recommend that the delivery 'chapter' of the report pays explicit attention to these 'within-government' issues.

(iv) Power, knowledge and influence

A growing body of research, to which Marmot and colleagues have made a major contribution, points to a significant causal relationship between inequalities in health and social, material, political and cultural inequalities including status hierarchies – the macro social determinants. This evidence suggests that substantial and sustainable reductions in health inequalities between social groups and areas of the country require genuine redistribution of power and resources within UK society and high quality universal provision to meet social needs including, but moving beyond, health care. This of course would require a broad based egalitarian ethos and commitment to social justice – which if they existed would undermine existing status hierarchies. We advocate the introduction of processes that enable the debate to take place about what sort of society people want to live in, and about the consequences across society of existing inequalities.

In the UK as a whole, but particularly in England, welfare systems and public policy in general mimic markets in the search for economic efficiency and higher productivity. The welfare system has been increasingly privatised and the long-standing concern that welfare services should support flexible labour markets has been reinforced. Social life, relationships and so on – the ethics of care – are largely secondary to, and intended to be adapted to, the work ethic and economic growth. The personalisation agenda, which aims to meet individuals' unique needs and includes allocating a care budget to the client, is effectively a consumerist agenda; area based regeneration initiatives are designed so that activities aimed at social development are subordinate to, and serve, the primary goal of economic growth (e.g. housing market renewal). The inevitable inequalities in life chances and living conditions that result are widely accepted as the price to be paid for wealth creation (albeit that wealth created is easily lost, at least for most people).

The health inequalities that result from these wider inequalities are typically, and in keeping with lifestyle drift described earlier, conceptualised as being the result of individual behaviours. Arguably, all this continues largely unchallenged because:

- England remains a class divided society: powerful forces resist any move for greater equality;

- This reality is compounded by the dominance of behavioural explanations for health inequalities;

- Public spaces (not places) that enable debate and shared learning have declined and daily life has become increasingly privatised in many areas. The lack of public debate locally, regionally and nationally contributes to an absence of shared narratives and meanings, and mutual respect; the foundations for collective action for change no longer exist;

- Politicians recognise the need for more authentic public engagement in decision making to legitimise their action and 'renew' democratic processes but policies have failed to shift the balance of power between public and professionals/the political classes.

What Lessons Can Be Learnt?

In addition to the specific issues raised already, our subgroup has identified some broader considerations: health inequalities as 'a wicked problem'; alternatives to the market model; social movements for change; and the current political and economic circumstances.

If real and sustainable progress on tackling inequalities in health and wellbeing is to occur, then it will require fundamentally challenges to the way things have been, and still are, done. Public health deals with 'wicked problems', namely those for which there are invariably no easy, or sometimes any, solutions. Such intractable problems demand to be constantly worked at and solutions to them negotiated and modified as knowledge about their causes and impact becomes available, and the circumstances surrounding them change. Moreover, the problems (and the requisite responses to them) are no respecters of boundaries or organisational silos. They cut across sectors, organisations and professions both vertically and horizontally. There is some effort made to recognise this in the emphasis on, and efforts devoted to, partnership working. Recent evidence shows that partnerships at present may be ill equipped to deliver, and incur high transaction costs. Their impact on outcomes is unclear: at best the jury is still out. Nevertheless, we are committed to the view that a locally-based, partnership model which is tailored to local circumstances and need, and works as a system (with its impacts being examined across that system) is the right direction of travel. New forms and ways of working may need to be found, but reverting to tightly-managed, target-driven, initiatives would, we are convinced, be a step in the wrong direction.

We also have an opportunity to ensure that more appropriate policies and interventions may be forthcoming. For example, the evidence suggests that a welfare system aiming to support

and promote social justice and a more equal society would need to provide boundaries to the operation of markets (not be subservient to them). It would consist of high quality, publicly funded, universally accessible welfare services that promote social cohesion and the values that sustain social co-operation. This would require a more redistributive tax system, but the better off would benefit directly from high quality services and indirectly from the social cohesion outcomes. Public policies would prioritise social development and design other policies to support this.

In the context of the WHO report on the social determinants of health, Marmot has recognised that the profound changes required to achieve greater health equity nationally and globally will not happen without 'popular' pressure and the emergence of a social movement. Obviously mass movements for social reform cannot be engineered. As David Donnison argued in 1982, in his case study of the Supplementary Benefit Commission: 'by themselves individuals can do little, but together if they know what they want and how to set about it people can shift apparently immovable institutions. And if enough people start doing that then the political climate itself begins to change' (p214). A crucial element would seem to be action to support/sustain a social movement for change. Implications for the Marmot review include:

- Stimulating a great inequalities debate – including influencing the media and public debates;
- Influencing the political process trying to influence manifestos and leading up to the election in 2010;
- Doing public engagement in decision-making better

Transformational change can also emerge out of specific historical-social circumstances. Again, referring to Donnison's influential work: 'from time to time in the course of its history a nation crosses a watershed in its political journey – a point at which the whole landscape of popular assumption and aspiration is seen to change'(p206). The global financial collapse of 2008/09 may represent the most recent window for transformational change – including an invaluable opportunity to bring together concerns about economic policy and environmental sustainability, with a focus on issues of inequity and the need not only to 'level up' but to 'level down'.

A new approach
The case for a new approach is overwhelming and yet it cannot happen without prior acknowledgement that merely tinkering with the status quo will not work. To admit this will not be easy because of the mind traps we all inhabit and which lock us into accepted ways of doing things even if we know (if we are honest) that these are not 'fit for purpose'. In

tackling health inequalities, the path dependent, whereby decisions are limited in some way, or default option is not the answer. We've been round this track too often in the past as our review of lifestyle drift has demonstrated.

It is not merely a case of fewer, or reformulated, targets or of reshaping Local Strategic Partnerships and Local Area Agreements so they will work better. The present system of targets, command and control direction, and structural upheaval needs to be radically modified if policy-makers and practitioners are to be liberated and encouraged to be innovative and think afresh. This is not as outrageous or outlandish as it may seem. Nor will it lead to chaos. And, finally, it does not require wholesale structural change. What it does demand is a shift in culture and in ways of working that in time may lead to organisational and structural change but of a type that occurs naturally and organically and is not imposed uniformly.

Our new approach starts with a realisation, noted above, that we are dealing with 'wicked problems', that is, problems that defy easy or single bullet solutions. They have complex causes and require complex solutions. They are usually difficult to define with precision, are interdependent and multi-causal, may give rise to solutions which themselves may have unforeseen or unintended consequences, are not stable, rarely lie within the boundaries or responsibilities of any single organisation, and involve changing behaviour – not just of the recipients of support but also of those dispensing it. Without an appreciation of these factors, getting traction on wicked issues will elude policy-makers. Leadership in such a context means switching from providing the answers to asking the questions. We do not have neat and workable solutions to problems like obesity, alcohol misuse or teenage pregnancy all of which are more evident in poor communities.

Starting from the premise that public health is renowned for its wicked problems, the key elements of a new approach can be set out as follows:

- Support for co-production of delivery model with public and practitioners working together to find and implement workable solutions;

- Importance of the co-creation of knowledge rather than evidence-based practice derived from what academics consider appropriate evidence with knowledge transfer being unidirectional;

- Start with the policy issue rather than with services, organisations or professions;

- An ability to remain comfortable with uncertainty;

- Encourage a culture of positive deviance not negative acquiescence. This means encouraging people to be innovative and take risks through escaping their mind traps and being prepared to think creatively outside the box;

- Think whole systems and not in silos;

- Build partnerships from 'coalitions of the willing', modifying them as circumstances change and dissolving them when the task is done;

- Develop leadership in improving health and wellbeing derived from complex systems thinking and quality improvement tools.

In place of a strategy of 'more of the same', the time has come for a much more searching and radical look at what is needed from public services, working with others, to meet the policy objectives enshrined in world class commissioning. As Task Group 7's report acknowledges, there is a readiness in public services for a new approach with some local areas already forging new ways forward but doing so *despite* rather than *because of* the current policy and service delivery arrangements. The challenge is to adopt such new approaches more widely if they are seen to work.

Conclusion

This report has sought to review why policy continues to have little effect on health inequalities in the UK and the lessons that can be learnt from the past. We have considered the current and past local delivery systems and mechanisms and their weaknesses; the idea of 'lifestyle drift' whereby policies do not achieve what they aim to due to a focus on individuals rather than the whole picture; the need to pay attention to how government deals with policy; and how power relationships and market systems seem to reinforce the polarisation of quality of health between rich and poor. We have also described what we consider may be a way forward in delivery and implementation to reduce inequalities in health.

For now, a priority should be to nurture and build on these fragile beginnings of a new approach rather than leave them to chance and, in some cases, almost certain failure. An environment needs to be created which fosters debate about redistribution, and about the type of society that the people of England want to live in and believe in. There needs to be sustained resistance to lifestyle drift and to silo-based working, and continued efforts against policy and delivery attraction to low-lying fruit. The necessary system transformation will not happen otherwise.

Appendix: How can the Marmot review report itself avoid lifestyle drift?

As part of its learning, this sub-group has also considered what other Task Groups involved with the Marmot Review have reported. In particular, it was noted that some have also flagged the potential danger of lifestyle drift, inadvertent though it may be. The report on *Priority Public Health Conditions* by Task Group 8 is a case in point. It makes a clear statement in "policy context" about the need to attend to the social gradient, not just disadvantaged groups, and to act upsteam, acknowledging that "the only way to achieve lasting reductions in inequality is to address society's imbalances with regard to power, income, social support and knowledge." (summary, page viii). It goes on to mention upstream and downstream action explicitly "the most effective strategy to improve health across the population and to reduce health inequalities, is to implement upstream policy interventions. However, these need to be supported by downstream socially-targetted interventions to mitigate any adverse distributional consequences" (summary, p.ix). It admits, however, that most evaluation evidence is on downstream interventions (which may influence perception of which actions are the most effective).

A total of 16 recommendations are made, which divide into two camps. On the one hand, there are very specific, concrete proposals for immediate, one-off, government action, e.g.:

- Recommendation 7: "introduce a minimum price unit for alcohol",
- Recommendation 8: "lower the legal blood alcohol content limit for drivers from 80mg of alcohol per 100ml blood to 50mg", and
- Recommendation 10: Widely extend 20mph maximum speed zones in residential and inner city/town areas".

On the other hand, there are very diffuse recommendations that beg the question "yes, but how?" For example, recommendation 5: "enhance the psycho-social wellbeing of lower socioeconomic groups"; recommendation 4 "improve infant and maternal nutritional status"; recommendation 13: "Decrease the association between mental ill-health and unemployment through the use of both targeted support and broader health promotion approaches". When the proposals for "how to do it" are examined, the drift towards individual, health educational approaches is discernable, together with a strong focus on the most disadvantaged groups/areas.

It is likely that a) the more concrete proposals will be seized upon and taken more seriously (even if not implemented in the end), and b) that even with the more diffuse proposals, the more concrete, and easier recommendations involving health education/promotional activities linked to lifestyles will be taken up in favour of the more complex, upstream actions.