All Party Parliamentary Group on Health in All Policies

Minutes of the second meeting of the All Party Parliamentary Group on Health in All Policies, held with the UK Faculty of Public Health on Wednesday 28 January 2014, at Portcullis House, Room Q.

Present

Debbie Abrahams (Chair)	MP for Oldham East and Saddleworth
David Ward	MP for Bradford East
Luciana Berger MP	MP for Liverpool Wavertree, Shadow Minister for Public Health
Professor Gabriel Scally	
Baroness Jay of Paddington	
Baroness Hollins	
Professor Sir Michael Marmot	Director, UCL Institute of Health Equity
Professor John R Ashton CBE	President, UK Faculty of Public Health
Dr John Middleton	Vice-President, UK Faculty of Public Health
Lindsey Stewart	Head of Health Policy and Advocacy, UK Faculty of Public Health
Mark Weiss	Senior Policy Officer, UK Faculty of Public Health

Introduction

Debbie Abrahams MP (DA) welcomed Professsor Sir Michael Marmot to this second meeting of the All Party Parliamentary Group on Health in All Policies.

Recognising that many of the key determinants of health are found outside of the scope of the health service, APPG members felt it fitting to pick up the baton from MM's Strategic Review of Health Inequalities in England post 2010, and its report, *Fair Society, Healthy Lives*[1].

DA welcomed MM's update on progress – at national as well as local level – towards implementation of the recommendations of his review, published prior to the 2010 General Election, and of the impact made on reducing health inequalities.

Professor Sir Michael Marmot (MM)

A sense of optimism – action on health inequalities is at the heart of the public health strategy

MM introduced his presentation with a sense of optimism at the traction that *Fair Society, Healthy Lives*, commissioned by the Labour Party and taken forwards under the Coalition Government, has had since publication in February 2010.

MM emphasised the importance of the 2010 Public Health White Paper,[2] produced in response to the Review, and which was said to have put the reduction of health inequalities at the centre of the public health strategy, and recognised the need to take action on the wider determinants of health.

This importance of this recognition, MM affirmed, should not be understated – being written down increases the likelihood of action. MM had in the intervening years worked with the current Government to help inform the advancement of the Review recommendations.

[1] Institute of Health Equity, *Fair Society, Healthy Lives*, 2010, http://bit.ly/1hs5CeE
[2] Department of Health, *Healthy Lives, Healthy People: our strategy for public health in England*, 2010, http://bit.ly/1kb0n1R

The Swedish experience – the 'Marmot brand'

The Swedish experience, where 'Marmot' has become a 'brand name', has been instructive in demonstrating the potential to embed on the national and local policy agenda effective mechanisms to take forward the Review proposals.

MM drew attention to local reviews of the social determinants of health that have taken place across Sweden, including in Stockholm, Gothenburg, Malmö, Linköping and Norrköping. The Review is still actively being discussed within the Swedish Parliament and the Swedish Government has recently confirmed that it is to undertake a national level review.

Local level action – Marmot principles, a top priority

In the UK, at the local level, there has been enthusiastic uptake of the Review recommendations. A King's Fund survey has outlined that in 49 of 65 Health and Wellbeing Boards, Marmot principles were cited as a top priority.[3] So, the Review – and a health in all policies approach – is on the agenda of local government, and not just on Clinical Commissioning Groups. MM noted that in March 2015, Coventry will be celebrating two years of being a 'Marmot city.'[4]

The national picture – a duty to have regard to health inequalities

Nationally, MM suggested that the *health in all policies* approach should be reframed as *health equity in all policies* - looking not just at the impact of health on policies in other domains, but on the fair distribution of health. To that end, it is, MM said, welcome that enshrined within the Health and Social Care Act 2012 is a duty on the Secretary of State for Health to have regard to health inequalities.[5] While this duty could be strengthened, it does percolate through the system, so that stakeholders know that health inequalities should be on the agenda – which is positive.

The economic recession – rising levels of child poverty and inequality

MM apprised APPG members that he had been commissioned to examine the impact of the economic recession on the London region, and found that it had had a likely adverse impact on housing, income and employment – a warning sign that all things being equal, health inequalities have worsened as a result of the recession.

MM noted with disquiet a recent Joseph Rowntree report which detailed that since 2008-09, the number of people in poverty, (living below the minimum income for healthy living) has risen from 20-29% of people.[6] Among families with children, the latest figures from 2012-13 show an increase of 31-39%. In this context, MM drew attention to the social gradient in health, along which the lower you are the higher the risk of experiencing poor health is.

With almost 40% of people in poverty, this is not a small high risk group, but a large proportion of the population towards the lower end of the gradient. And, with much current rhetoric about people not wanting to work, MM further noted that for families where one adult is in full time employment and the other is not working, 51% are in poverty.

MM affirmed that an evidence based (and non-political) health equity in all policies approach would help to address the underlying causes of these statistics. The economic recession has laid bare a

[3] The King's Fund, *Health and wellbeing boards one year on*, 2013, http://bit.ly/1BalmhI
[4] Eventbrite, *Making a difference in tough times: Coventry celebrates two years as a Marmot City*, 2015, http://bit.ly/1wa1XwV
[5] National Archives, *Health and Social Care Act 2012, Section 4*, 2012, http://bit.ly/1BNPMH9
[6] Joseph Rowntree Foundation, *Households below a minimum income* standard, 2015, http://bit.ly/1C2Xxsg

need to address the way in which social and economic resources are distributed in society as a whole – not just in relation to the poorest.

Half of children are not ready for school at five – reducing deprivation would reduce inequality

MM updated APPG members that his team have been monitoring the situation in relation to the six domains of the Review report, with the last set of data issued in autumn 2014.[7] The data received attention for its conclusion that half of children have not reached the required standard for school at age five. While tracking the data over time is challenging as levels of deprivation change. Notwithstanding whether the situation is getting better or worse, it is, MM asserted, awful.

While 51% of those families outlined are in poverty, this follows the social gradient, so that the more deprived the area, the higher the proportion of children not ready for school at age five. This suggests that one way of reducing inequalities in child development is to reduce deprivation. MM remarked that those on the left may contend that the reason for lack of school readiness is poverty, while those on the right may contend that the reason is poor parenting. Both, however, are correct.

The quality of parenting is related to the environment in which parents are trying to be parents – and if you are one of those families mentioned above and do not have enough to heat the house and feed the children – this is a very stressful position for the family to be in. While all parents should be good parents, the environment in which they are trying to be parents makes a huge difference. And, although in theory those who are unemployed have a larger degree of time, in reality they also have tremendous pressure. This in turn has a very detrimental impact on child health.

Cutting services for early childhood increases the impact of deprivation

MM noted that our understanding of the social gradient in early child development, and of why some children are doing better that others, is very good. Services to support parents during early child development matter.

Luciana Berger MP (LB): LB asked whether any analysis has been done of the impact of specific services that have been cut on increasing levels of inequality. LB referred to the early intervention grant in Liverpool as an example.

MM responded that the evidence is compelling that where services for early childhood are cut, this has a potentially damaging impact, and that provision of services can blunt the impact of deprivation. By way of example, MM described the situation in Tower Hamlets, where the local authority education team were clear that the improving social gradient in educational performance demonstrates that the link between deprivation and poor school performance has been broken – that 'poverty is not destiny'.

'Proportionate universalism' – progressive taxation is part of the solution

Baroness Hollins (BH):BH asked whether the gradient of the inequality index is itself a contributor – e.g. if there is a steep gradient, with a lot of people in a borough rich and a lot of people below the poverty line, is the gradient itself having an impact as well as disparities in income levels?

In MM's view, it is not the gradient per se. MM observed that the wealthy are intolerant of and find ways of avoiding tax, and that this has got worse, with the top 20% paying approximately 35% in income tax while the bottom 20% pay approximately 38%. This means that, where wealthy people

[7] Institute of Health Equity, *Marmot Indicators 2014: A Preliminary Summary with Graphs,* 2015 http://bit.ly/1ppPhIh

enjoy their own arrangements for taxation, there is less money to spend to help the poorer people across the gradient.

Professor John Ashton (JA): JA described a fundamental argument between universal vs. selective policies and benefits, paradoxical, he felt, in the context that the Conservatives have pledged to keep the winter fuel allowance while Labour have suggested that they will remove it to save money. If the middle class does not benefit from universal provision, JA said, it will disengage from it.

MM described the term, proportionate universalism, outlined within the Review report. With a progressive taxation system and universal benefit, society would get money back through people paying more tax. However, in the absence of a progressive system of taxation, a system of indirect (and far more regressive) taxation is having a very damaging effect on inequality.

MM was clear that in the present circumstances, with a very mildly progressive income tax coupled with sharply regressive indirect taxation, it is not difficult to understand why people object to a universal benefit system as they may experience little of it coming back. With a properly progressive tax system, the benefits will return, so, for example, city lawyers who pay child support pay it back in tax.

Baroness Hollins (BH): BH asked whether MM had a sense of what specific services, in regard to education and beyond, were thought to be making the difference in Tower Hamlets?

MM explained that the education team felt that they were the key to the improvements, through high quality teaching. Baroness Jay in turn suggested that Academy funded schools and new head teachers had made a large difference.

MM drew attention to the Finnish education system, which has the highest PISA scores of OECD countries.[8] In Finland, MM observed (in the example of one head teacher he had visited), that catchment areas are split into three groups – deprived people, the artistic community and the middle / professional level. The number one priority is to get all of those children from deprived backgrounds into the mainstream – almost a perfect description of proportionate universalism. There exists no private education, and the aim is supported widely by both side of government, from left to right.

In Finland, teachers are paid well and have a lot of self esteem. All have masters degrees, and see their role as reducing inequality as well as raising standards.

Professor John Ashton (JA): JA welcomed MM's recognition of the readiness for schools indicator. JA drew attention to differences in approach in Scandinavia, and the way readiness is conceptualised and cultural framing of the issue.

MM recognised this cultural variation, although did not feel that it detracts from standard measures for early child development. MM drew attention to work that the IHE had been commissioned to undertake to develop outcome measures to assess the quality of outcomes in early childhood. The measures developed by the IHE team are, he felt, likely to be internationally applicable.

[8] Organisation for Economic Cooperation and Development, *Programme for International Student Assessment (PISA) 2012 Results*, http://bit.ly/1cSKOcS

MM noted the report card produced by UNICEF, which looks at inequality in early childhood, and factors in poverty, learning, health and other measures for all OECD countries, and the UK's poor performance in report cards 9 [9]and 11.[10]

Disempowerment – material, psychosocial and political

Debbie Abrahams (DA): In relation to the protective factors needed for services in areas of deprivation, DA asked what influence might be exerted and actions taken on to shift organisational decision making and power towards ensuring that these protective factors are fully taken into account.

MM underscored the important impact of disempowerment as both an organising principle and also in demonstrating empirically the evidence that people with less control over their lives have worse health. Disempowerment, MM affirmed, can be thought about in three ways:

- **Material:** If you are one of the 39% below the minimum income necessary to have a reasonable life, you are disempowered.
- **Psycho-social:** If you do not have enough money to feed your children, you have limited control, which is very stressful. Poverty is a good way of disempowering people.
    - There is good reason to believe that there is a relationship between stress pathways and poor and damaged mental and physical health.
    - Disempowerment can also take place in the workplace, and has a range of associated problems, e.g. increased risk of heart disease, mental illness and risk of sickness absence.
    - Disempowerment at work follows the social gradient, and is related to the degree of control one has over ones work. With less control, health is damaged. MM drew attention to the Whitehall study of civil servants,[11] which explored this issue. Independent of social status, if one has less power at work, and less control, ones health is more likely to be damaged.
- **Political:** MM emphasised the importance of having a voice.

Addressing the power imbalance – the value of good pubic services

Debbie Abrahams (DA): Given the examples mentioned of how Scandinavian countries address inequalities in their education systems, DA posed the question of what this means in terms of how we may organise our societal institutions more generally, and how we might seek to address historic power imbalances.

DA drew on her own experience as a member of the Pensions Select Committee and the issues raised by her members during her surgeries with regard to work and pensions through tax credits. DA noted the disempowering nature of the process and often poor treatment of her members when in contact with the benefits system.

MM accepted that addressing historic imbalances in power is challenging. He emphasised that in consideration of how to define the minimum income required for healthy living, the IHE are clear

[9] UNICEF, *Rich countries letting poorest children fall, says new report*, 2012, http://bit.ly/1CGrmAG
[10] UNICEF, *Report Card 11: Child well-being in rich countries*, 2013, http://bit.ly/1Np8F7U
[11] The Lancet, *Health inequalities among British civil servants: the Whitehall II study*, 1991, http://bit.ly/1BavmY7

that part of the definition relates to having enough money to participate fully in society and lead a life of dignity. To that end, money, while important, is not the only important factor.

With good public services, e.g. schooling, transport, health care free at the point of use, clean streets, parks, amenities, libraries – less money is required on an individual level. In this context, libraries are wonderful resources that have been transformed to almost replace public houses as communal meeting places. In sum, how important money is depends on what the community provides.

Professor John Ashton (JA): JA stressed that the framing of this discussion has been in recent years more about money, referencing Richard Titmuss' work on control over resources over time, which included a wide range of resources that are relevant in the context of a social wage. Members agreed that in the context of the discussion about being treated with dignity, this is very important.

MM in reference to a book he is currently writing, quoted from the play Pygmalion, in which Alfred Doolittle describes himself as "one of the underserving poor", and highlighted the detrimental impact on those families with children with only one adult in full time work and who are living below the minimum income level – should they be thought of as worthless or feckless.

Professor John Ashton (JA): JA noted the phenomenon that poor children in wealthier areas behave worse than poor children in poorer neighbourhoods.

MM described his own evidence, and that of a colleague from the United States, which shows the contrary. If poor people are in a poorer area they are worse off and their health is worse. This results from a range of factors that include fewer and lower quality amenities, greater fear of crime and the generally worse properties of a neighbourhood (including poverty). Looking at the social gradient by education or income and grading areas by deprivation, the worst scenario is to be poor in a poor area. It is better to be poor in a richer area.

Lindsey Stewart (LS): LS recalled Richard Wilkinson's book, the Spirit Level,[12] which concludes that high levels of deprivation bring the whole of society down. If we can tolerate that level of deprivation and disadvantage, that impacts on even the richest in a negative way.

LS, in discussing universalism, referred to the policy that every child that goes to nursery/primary school has free school meals up to the age of three. The point about non-means tested meals, LS said, is to lift society up and make accessibility easier for the disadvantaged. While the flip side is that wealthier people benefit, the aim is to create the conditions for greater social mobility.

Professor John Ashton (JA): JA drew attention to a paper looking at historical data on aristocrats living in different geographies experiencing differing life expectancies – so that if 'well heeled' but living in a poorer environment, this may be health limiting.

While an attractive idea, MM said that the evidence suggests the opposite. Office of National Statistics data on the social gradient and mortality by socio-economic classification does not demonstrate any geographical variation at the top of the social hierarchy. The lower one is on the social hierarchy, however, the greater the disadvantage of being poor in a poor region.

David Ward MP (DW): DW, drawing on his own experience representing constituents in a very deprived area, stressed that in his experience, poor people were not living in rich areas.

[12] The Equality Trust, *The Spirit Level – Why equality is better for everyone*, 2015, http://bit.ly/1BaslXW

MM contrasted this with his experience living in Hampstead, where local authority housing is situated in an area of very good amenities, clean streets and so on, all of which benefit those more socio-economically disadvantaged residents.

A stark perspective was offered by DW, who drew attention to the fact that his constituency experiences the highest level of child poverty in the Yorkshire region and sixth highest unemployment rate in the country – such that one can tell from one side of the road to the other where the more affluent people live. Poor people can not afford to live where the rich live, and can not afford the rent or the housing.

MM clarified that his response was to the question of whether poor people living in wealthier areas are better off than those in poorer areas, and if they don't live in those areas in the first place then the question does not arise. Also, MM mentioned that he was approaching the question in terms of the ONS data from a regional, not local neighbourhood, perspective.

DW noted that that it is at the local level that the consequences of inequality are felt, and where policies need to intervene to ensure that, for example, there are children's centres in every community and to address whether resources are focused on those areas with the greatest deprivation. By treating people who are unequal unequally, it simply reinforces the inequality, which is the argument that DW has made against universality.

MM did not disagree, and reinforced the message that *proportionate universalism* is the key, and used by example the NHS, and, in particular, questions relating to provision of diabetes or renal disease, which cost the NHS a great deal of money – but which are funded proportionate to need.

A second example, education, was presented. All would agree that we want an education system that works as well at both ends as well as in the middle – to provide the opportunity for the elite to flourish (e.g. those who produce the best movies, science, books and so on); but in so doing to ensure that people should not lack the ability to flourish simply by virtue of where they live or who their parents are. So, universal provision is required that is proportionate to need.

The intergenerational impact of disadvantage – mental health and wellbeing

Baroness Hollins (BH): BH highlighted the way in which disadvantage crosses generations, especially from the perspective of mental health problems which recur generationally (the subject of BHs first paper) – and the impact this has on sustaining inequalities. BH asked MM the extent to which he felt this aspect contributes to inequalities.

MM made two observations, while recognising that more evidence is needed in this area:

- Depression and post-natal depression follow the social gradient, and for children of mothers who are depressed, there is an adverse impact on development. This, MM asserted, is a ready mechanism for social transmission.
- There is a growing awareness that serious mental illness and post traumatic stress, including from domestic violence and abuse, impact on a mother's ability to relate and attach properly to their children. It is possible that for those from a poorer background, there is less likely to be support to address these issues, for example there may be more limited access to health (including mental health) services.

MM noted a Californian study, which examined the issue of adverse child experience, in which the population studied were enrolled in the Keiser Permanente health plan, and, interestingly therefore,

were not the poorest members of society. Yet, the greater the number of adverse child experiences, e.g. physical, sexual or psychological abuse, the poorer were the mental health outcomes in adulthood among those studied. The fact that this was mirrored in physical illness suggests that reporting bias is not interfering with the results.

Members agreed that this comes back to the idea of proportionate universalism in that more and better services are required to meet the needs of those most affected, especially for early intervention.

To what extent should the state intervene?

In reference to the line between where individual responsibility and the role of the state should be drawn, MM was clear that his route into that discussion is firmly through the evidence base.

Following this line of thought, if one says that it is individual responsibility, for example to eat and drink sensibly, MM posed the question of why social gradients exist in the first instance, and what is causing them? MM questioned why it is that the rise in childhood obesity has levelled off in children in better off families, yet worsened in worse off families. Are the children irresponsible? Are the parents to blame for not being able to afford better food? Are we to blame the next generation for the previous generation?

If we live in a caring society, it is, MM made clear, we have some wider responsibility to address these problems – because the evidence shows that we can interrupt them.

Baroness Hollins (BH): BH, in consideration of the Work Capability Assessment (WCA), noted with disquiet that while it is the case that we know if somebody is without money for food or accommodation that this is damaging to their health; that under the WCA claimants may wait for as much as two weeks before receiving payment. This situation, which ought not to be acceptable, appears to be exactly so – and for disabled people the impact on health is greater.

BH, and APPG members found shocking the implication that it is in some way acceptable to damage a person's health by allowing them to remain in a situation where they have no access money for food or shelter.

Poverty has a detrimental impact on executive and cognitive function

In response, MM referred to a book, *Scarcity: The New Science of Having Less and How It Defines Our Lives*, in which the question is asked whether poor people are poor because they make bad decisions, or whether they make bad decisions because they are poor. In the example of the United States, MM discussed evidence that the poor are less likely to take their medication, to do what their diabetic clinic has told them to do to look after themselves or their children.

MM noted that the evidence suggests that being poor reduces ones executive and cognitive function, so, for example, if one is hungry one focuses on the immediacy of the hunger, rather than the means to address the wider reasons for that hunger. DA noted that this is in accordance with Maslow's heiercachy of needs.[13]

Poverty, MM asserted, reduces ones 'bandwidth' and executive function – and the impact of this is felt from early childhood. Relieving poverty improves cognitive function. This makes use of the evidence to inform policy of critical importance.

[13] Wikipedia, *Maslow's Heiercachy of needs*, 2015, http://bit.ly/1kSipGu

DW, in consideration of what level and stage in life funding should be made available to address this issue, supported a focus on early intervention, given the profound impact poverty may have had very early on. To that end, DW felt that not only should work be done to address very early childhood, but that pre-childhood interventions are needed, e.g. work with expectant mothers on nutrition and diet. DW welcomed the Pupil Premium and free school meals.

DW mentioned that while many have suggested raising educational attainment is the key to addressing poverty, his own position has been the reverse – that reducing levels of poverty and deprivation is the key to addressing educational attainment. Summarising this line of thought, DW was clear that he does not believe in the freedom of people to be poor.

A freedom to be poor?

MM, continuing this theme, agreed that nobody would claim not to believe in the notion of freedom, and that democracy is a popular system because it guarantees the greatest level of freedom. However, poverty is restrictive of freedom. This, MM said, operates in the same sense of freedom as that discussed by Amartya Sen in his own work. Mr Sen had in fact contacted MM some years ago after having read his work and felt that they were talking the same language.

The key issue is the degree control one has over ones life. MM briefly discussed the hypothetical example of someone living in an impoverished area of Glasgow, who had faced a difficult life and suffered from abuse, moved house every year, been a juvenile delinquent and in trouble – and now has the freedom to be miserable, angry, drunk, depressed and thrown out by girlfriends who he now abuses.

That, MM remarked, is not a wonderful freedom. Get the conditions right, however, and, by contrast, should he wish to climb a dangerous mountain face, with a high degree of risk, if he happened to fall and injure or kill himself, in that situation one might say, ok, he knew what he was doing and understood the risk involved.

DW added to this discussion, that during his time as a Councillor, many years ago, he was a spokesperson on housing. At that time, he used to say that housing was the most important area to get right to improve equality. Following that, DW worked in the field of education, and, similarly, would argue the case that education is in fact the most important factor.

Over the years, however, DW said that he had come to the view that in fact the most important factor is health – because everything else, whether lifestyle, housing, where you live – almost everything is impacted by health. And, if you have health, then other things become possible. MM thanked DW for this observation which he found eloquently expressed what he was trying to get across.

Conclusion and recommendations

Debbie Abrahams (DA): In view of the wide ranging discussion above, and latest IHE update published in Autumn 2014, DA invited MM to recommend to the APPG those areas of focus that would be most helpful for the APPG to address moving forwards. In that context, DA recognised that in 2002 when the Treasury undertook a cost cutting review of health inequalities, it did not look at macro-economic policy.

MM made the following recommendations to the APPG.

1. **How well are we doing?** All governmental departments and the Prime Minister should be interested in health equity because if on some level the mission of politics is to improve the wellbeing of the population, then the fair distribution of health (including mental health and wellbeing) is the best and most reliable measure of that.[14]

2. **How do we get there?** Having a cross-ministerial activity and cross activity of senior officials is critical to ensure that health inequalities will be reduced.

3. **A solid evidence base:** It is vital that policy is informed by what the evidence says.

A public health act and requirement for health equity impact assessments to be undertaken

Debbie Abrahams (DA): DA, in consideration of MM's three recommendations, posed two further specific and related questions, to refine how a health equity in all policies approach might be taken forward:

1. Would the re-establishment of the Department of Health's Health Inequalities Unit be a useful step?

2. Would a Public Health Act that includes a health equity in all policies approach be a useful step?

Cross departmental working

MM was clear that both recommendations would be useful. In terms of the former, should such a body be developed, this should ideally be co-owned and managed by different government departments, allowing for effective joined up policies and fostering cross-departmental buy in (DA suggested that matrix management would be a helpful approach).

MM noted that until November 2012, there had been a cross-ministerial Cabinet sub-committee on public health, before which he had given evidence. Having a cross ministerial activity of senior officials in different departments, MM stressed, is important to ensure that there exists a common agenda – not because those working in health wish to take over the remit of other areas, but because if those areas fully account for health inequality in their work, inequalities will diminish.

MM referred by way of example to the money spent through and pressure on the welfare system that could be averted if people in work were both paid a sufficient amount and had access to affordable rents.

David Ward MP (DW): DW agreed on the importance of cross-departmental working, and drew attention to the 'silo mentality' that is easy to develop, where officials work towards the targets of their individual remit. DW recalled his experience in the 1980s working in Bradford Council at a time when the Council was trying to address race relations. At that time, every report that came to the Council for consideration had an 'RR' (race relations) stamp, to demonstrate that the obligation to consider this important area had been fulfilled.

[14] By unfair distribution of health, we mean those social inequalities in health judged to be avoidable by reasonable means, which are the deepest and most unjust inequalities of all

Taking this idea forward, DW suggested that it would be helpful if an "H" might be stamped on all policies, whether transport, social or environmental – so to ensure a common agenda and that departments are not be at loggerheads with one another.

MM agreed, and suggested that if health equity was taken into account, work would be organised differently. To that end, mechanisms are required to allow for cross-sectoral working. MM spoke positively about how 'Marmot' local authorities are working towards this form of partnership.

DA observed that at the European Union level, impact assessments are undertaken as a matter of routine, and a mechanism to determine whether there is a requirement to do so exists. In the UK context, DA provided a critical overview of the variable quality of those impact assessment processes that exist.

DA, in the context of the third of MM's recommendations, asked how a system to support better evidence in policy making, including a process around health equity impact assessment, might be developed – conscious that it would need to be of high quality and operate according to a rigorous process.

The value of independence from government

Responding, MM spoke positively of the fact the by definition, the APPG represents all parties. MM was clear on the importance that whatever body may potentially be set up should not be abolished by future governments. By example, his own Institute, while funded by the Coalition Government, emerged from a review commissioned by the Labour Government. A potential body must therefore not be party political (DA noted that the Bishops made a similar point when their recent report was published).

MM, giving some further context, drew attention to the recent statement by the head of the US Federal Reserve, in which she expressed deep concern that levels of inequalities have gone too far. DA added that the head of the International Monetary Fund had also recently made a similar position, while In turn, the Organisation for Economic Cooperation and Development has been clear that too much inequality damages growth. All agreed, that this is not a party-political issue, but cross-party issue.

MM explained that this concern with the widening gap in and levels of inequality is a powerful case for taking action to address health inequity – and that addressing this would in turn help to address and improve growth. In this sense, he agreed that DA's suggestions would be helpful in addressing inequality.

DA asked whether it would be of value and help to ensure a more robust process if such a potential future body, that addresses inequality, is situated outside of and independent of the 'Whitehall bubble', and has an academic rigour and reputation.

MM agreed, and drew attention to the IHE, which was set up to be like the Institute for Fiscal Studies, with the critical ability that comes from its independence integral to its successful operation. The IHE could not be seen as the property of a particular government department to ensure its credibility and ability to present impartial evidence based recommendations.

Coordination of work both within and outside of health services

Dr John Middleton (JM): JM noted that the former Health Inequalities Unit had a valuable managerial input into local authorities and Primary Care Trusts. JM also emphasised the importance of the sixth of MM's Review report recommendations, which recognised the role health services can play in making a difference to health equity, e.g. through early interventions, resource allocation, secondary prevention of coronaries and smoking cessation. DA agreed, and stressed the need for coordinated work to address health equity both within and outside of health services.

In this context, MM apprised APPG members that he is now President Elect of the World Medical Association, and is focused on trying to ensure that doctors are engaged on the social determinants of health and driving forward the Review Report recommendations in this forum.

DA thanked MM for all of his time, and welcomed his positive appraisal of action to embed a health equity in all policies approach at local level. At a national level, DA recognised that there is more to do, and welcomed MM's recommendations to the APPG as a potential way forward and move in the right direction. DA spoke enthusiastically about having cross-party support for work moving forwards, and noted that Jeremy Lefroy MP had wanted to be present.

Action point

JM, on a practical note, pointed out that MM had a PowerPoint presentation, and asked whether it might be possible for MM to share this with Mark Weiss, who can in turn forward this to APPG members. MW will follow this up.