



Select Committee on Science and Technology

Corrected oral evidence: Ageing: science, technology and healthy living

Wednesday 11 March 2020

3.20 pm

[Watch the meeting](#)

Members present: Lord Patel (The Chair); Lord Borwick; Lord Browne of Ladyton; Baroness Hilton of Eggardon; Lord Hollick; Lord Kakkar; Lord Mair; Baroness Penn; Viscount Ridley; Baroness Walmsley; Lord Winston; Baroness Young of Old Scone.

Evidence Session No. 21

Heard in Public

Questions 188 - 198

Witness

Professor Sir Michael Marmot, Director, UCL Institute of Health Equity.

USE OF THE TRANSCRIPT

This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witness

Professor Sir Michael Marmot.

Q188 **The Chair:** Good afternoon, Sir Michael. I know you are an extremely busy man, so we appreciate it very much you making time to come to see us today. I know your time is restricted and we will try to get through the questions in the time that you have allocated to us. Before we start, and so we have it on record—we all know you—please say who you are. If you want to say anything at the beginning, feel free to do so, otherwise I will get on with the questions.

Professor Sir Michael Marmot: I am director of the Institute of Health Equity at UCL.

Q189 **The Chair:** My first question is to ask you to summarise the findings in your extremely interesting and informative report in the context of our inquiry, which is mainly about the Government's Grand Challenge to improve healthy lifespan. What implications do your findings on health inequalities have on healthspan and lifespan, and therefore for this inquiry?

Professor Sir Michael Marmot: In sum, from the end of the 19th century, life expectancy improved about one year every four years for men and women, which is quite remarkable. Over the last 20-odd years it has been slightly slower for women than for men, so men caught up a little. That changed remarkably in 2010-11. An increase of one year every four years for men slipped to one year every 16 years and an increase of one year every five years for women slipped to one year every 25 years. It was a dramatic slowdown.

Putting it in other terms, for men it was an improvement of about 12 and a half weeks a year, which slowed down to an improvement of about three weeks a year. For women it was a bit less, at about 10 weeks a year, which slowed down to fewer than two weeks a year. There was a dramatic slowdown in the improvement in life expectancy. As I said, it nearly ground to a halt.

The other key background was the continued increase in inequalities in life expectancy, and it was not just an increase. We have documented the social gradient for some decades. It is not just that poor people have worse health than everybody else; it is a graded phenomenon. If you classify people by grade of employment in the Civil Service, education or index of multiple deprivation of the area of residence, the gradient runs from the top to the bottom of society. That gradient got steeper over the last decade.

Even more troubling, when you look at the combination of region and deprivation, you see an intersection. For people in the least deprived decile—I am describing graphs, so forgive me if my verbal description is not as powerful as the graph—there was very little regional difference in life expectancy. If you are in the top 10%, it does not matter much where

in the country you live. The more deprived the area of residence, the greater the impact of geography.

Thus the differences, say, between London and the north-east were much bigger for people in the most deprived areas and quite small for people in the least deprived areas. And for women in the most deprived areas, for every region outside London and the north-west, life expectancy declined in the bottom decile. It was not just that the inequalities were increasing; life expectancy was getting worse, for women in the most deprived areas.

I cannot keep up with the ONS. Yesterday, it published new figures on mortality which show that among men under 75, as well as women, from 2011 to 2018 mortality went up in the most deprived 10%. We have this picture of an overall slowdown in the improvement in life expectancy, increasing inequalities and actual decline in the bottom 10% in every region outside London and the north-west.

May I answer the other part of your question about healthy life expectancy? We do not have figures going back 100 years on healthy life expectancy. We have more recent figures, though, which show that the years spent in ill health have been increasing since 2010-11, particularly for women, which means that the impact on healthy life expectancy has been bigger than the impact on life expectancy. That is really troubling, of course, because if our aim is for people to live not just a long time but a long time in good health, we are going backwards.

The Chair: What implication does this have on the Government's Grand Challenge to improve healthy lifespan by five years by 2035?

Professor Sir Michael Marmot: That is 15 years from now. It means that if we restored the historical trend of around one year every four years, it would be two and a half years in 10 years, and in 15 years that would be 3.75 years for men and a bit less for women, so just in terms of life expectancy we would not make it. If we restored the pre-2010 historical trend, we would not make it. In healthy life expectancy, the inequalities are bigger and the social gradient is steeper, so the impact of the determinants of inequalities in health—we can talk about this in a moment—are bigger when we look at healthy life expectancy than when we look at life expectancy.

As I said, if we restored the pre-2010 historical trend, we would not make it for life expectancy and we certainly would not make it for healthy life expectancy. We would have to do more than restore the historical trend.

Q190 Baroness Young of Old Scone: Could I ask a question that I have not seen the answer to? The scattergram from your report on healthy life expectancy at birth, mapped by the Index of Multiple Deprivation score of upper-tier local authorities, seems to show that even if you are in the highest income or wealth brackets, you still have a period of unhealthy life at the end of your life. Is that an irreducible minimum, in your view, and how long is it?

Professor Sir Michael Marmot: I hope it is not an irreducible minimum. On average, people at the top are living about 12 years of their life with

ill health and people at the bottom are living about 20 years of their life with ill health.

Baroness Young of Old Scone: Twelve years is quite a long time.

Professor Sir Michael Marmot: Twelve years is quite a lot. Obviously, I focus on inequalities, but our key message is that we want to improve health for everybody as well as levelling up. They are two key aims. Speaking as somebody who is probably near the top, I would quite like those years of healthy life to increase.

We want everybody to have as short a period living with disability as possible, not because they die early but because they have longer years of healthy life. It is clear all the way down. The implication of the gradient is that we should not be focusing only on the very bottom. We want everybody to have more years with healthy life. Everybody below the top has more years spent in ill health than those at the top, and it runs all the way from top to bottom.

Baroness Young of Old Scone: Do you have a hunch, or even something based on data and evidence, as to which two or three determinants of ill health really stand out as the ones that need to be tackled? How has the austerity overlay influenced that?

Professor Sir Michael Marmot: I argued with my colleagues at great length about how we were going to formulate this. I was at the cautious end of the spectrum. For my Marmot review of 2010, we assembled more than 80 experts. We had a distinguished group of commissioners and we were pretty confident that we understood the causes of health inequalities. As I have cited somewhere, departing from my natural modesty, the Royal Society for Public Health did a survey of its members of the major initiatives in public health for the 21st century. Number one was the smoking ban, number two was the sugar levy and number three was the Marmot review of 2010. The community thinks we have got it right, too. We understood the causes of health inequalities.

Over the next 10 years, as health inequalities got bigger and life expectancy stalled, most but not all of the six that we identified in 2010 got worse. Can I say which caused the damage? No, I cannot. I would like to, but I cannot.

Baroness Young of Old Scone: You do not have an implicit league table in your head which you want to share.

Professor Sir Michael Marmot: The increase in child poverty, for example, is very serious and has very serious implications for today's children for the rest of their lives. It probably played no role at all in the worsening picture over the last 10 years, because it will take another 50 or 60 years for that to play out. If the implication was, "Let's focus only on what has got worse in the last 10 years and ignore child poverty", I would be terribly upset. On the other hand, if I said, "Let's focus on child poverty", we would not have addressed what might have got worse in the last 10 years. That is why I have always resisted saying it is this one or that one that is the priority.

I have certainly asked myself what has happened. I have just finished reading Case and Deaton's *Deaths of Despair*, which is due to be published in the next few days, because I am reviewing it for the *Lancet*. In it, they talk about the lives of people without a four-year bachelor's degree in the US and how they got worse. It has real resonance with the picture in Britain. It is worse in the US, because their incomes declined more. In Britain, incomes for people in the bottom 20% were largely preserved for a long time, so they did not get worse as they did in the US.

That was a very important difference. In general, people towards the bottom did not get poorer in Britain, but over the last 10 years poverty went up, particularly child poverty. That means more resort to food banks, more difficulty paying the rent and more struggles with life. There are any number of explanations. My previous body of research focused on psychosocial pathways and how being under stress disempowers people and increases the risk of heart disease and mental illness. I have ample potential explanations of what might have happened quite quickly over the last 10 years, but I have resisted saying that I know what it is, because I do not; it is too difficult to pin down.

Q191 Lord Hollick: Did the Government consult you or your institute before they decided upon the aims and objectives of the Grand Challenge and, in particular, the health inequalities? Did they draw upon the work that you and your institute had done over the last 40 years?

Professor Sir Michael Marmot: No, they did not. When I published my 2010 review, the Government issued a public health White Paper, which I was very pleased with, saying that they accepted my report and that the reduction of health inequalities requires action on the wider determinants of health. I used to brief every Minister of Public Health. Being appointed Minister of Public Health you have a short half-life. I counted up the number I briefed, and it was 11 in about 15 years, so the half-life is less than 18 months. However, they have stopped asking me to come and talk to them.

Lord Hollick: Is there a body of academic work that supports the reasonableness of the achievability of this objective, or was it perhaps just plucked out of the air?

Professor Sir Michael Marmot: They certainly did not consult me and, as I said in answer to the Chair's first question, I do not think it is achievable, even if we restored the pre-2010 rate of improvement in life expectancy. Like most scientists, I would ask you not to ask me to predict. I have enough difficulty explaining what happened, as I just said in response to the previous question. I cannot predict. But it is not achievable if we just extrapolate it from the pre-2010 trend.

Q192 Viscount Ridley: You have already mentioned America. How does the UK compare with other countries in this respect? Do you see the same flattening of the graph in other European countries, and the same steepening of the inequality gradient?

Professor Sir Michael Marmot: We certainly see the flattening of the graph in most European countries. If you compare the five years 2006 to 2010 and the next five years, 2011 to 2016, you see a slowdown in most European countries, which, broadly speaking, is consistent with the effect of the global financial crisis and policies of austerity that were put in place. We were third from the bottom for men and bottom for women. Even European countries that had a longer life expectancy than we did had bigger increases than we did.

The speculation that perhaps we have reached peak life expectancy and it has to slow down some time is not supported by looking at other European countries. When we look beyond Europe, it is only the US among the big countries that looks worse than we do. The US, as you probably know, had a decline in life expectancy three years in a row. A big component of that was deaths of despair—deaths from drugs, alcohol and suicide. Yes, we see it in other European countries, but it is not as marked as in the UK. I say the UK, but my recent report covered only England. The picture is worse in Scotland, Wales and Northern Ireland than it is in England.

Viscount Ridley: May I ask a quick supplementary, going back to something you said earlier about the subjectivity of healthspan?

Chris Whitty in one of our very first sessions talked about how hard it is to define healthy lifespan. You said that there are measures that one can use from about 10 years ago. Are those ones that we can consistently rely on? How do we know there has not been a bit of goalpost shifting or something in the way people think about what is healthy and what is not healthy over that time? I am interested in this, because healthy lifespan seems to be quite a slippery concept, so we have to try to get it right in our report.

Professor Sir Michael Marmot: I am with you. I agree completely. Let me answer your question by giving you a slightly different observation. When we compare the UK with the US, whether it is life expectancy or doctor-reported illness or biological markers, the US looks worse at middle age than the UK. The one measure by which the US looks better than the UK is self-reported health. By every other marker they look worse, and the one they look better in is self-reported health. You think, “What on earth is going on?” Presumably, as you are speculating, and I agree with your speculation, by that subjective measure the US was all gung-ho; “We are all happy and healthy. It’s just terrific”.

If you compare the US with the Japanese, the Japanese look better than the US on any marker you can think of, whether it is life expectancy, crime or inequality, except happiness and self-reported health. There, the Japanese are right down at 50%; “We don’t deviate, we are right in the middle. We are not healthy, we are not sick”. It is a problem. It is a much better predictor within countries than it is between countries.

Self-reported health is a very potent predictor of mortality within countries, as I have just been describing. It is not a very good predictor between countries. I agree with your concern, and it is a genuine reason to be concerned. It is why most of the time we talk about life expectancy.

It is not because it is the most important thing for people. Who cares about another 0.5 years of life? No individual cares about that, but it is a very important indicator. We count deaths with a fair degree of accuracy, but we do not count health with the same degree of accuracy.

The Chair: You said that your data was for England and that the situation in Scotland and Wales is worse. Are you collecting data for other nations in the UK, or is somebody else?

Professor Sir Michael Marmot: The ONS publishes data for England and Wales, so we get the Welsh data from the ONS. NHS Scotland has been collecting the data for Scotland. In fact, I have been to Scotland quite regularly. I was last there in December, and the person analysing these data for Scotland said, "This is unprecedented. We have never seen an impact on the health of the Scottish people like we have seen over the last decade". I am going back to Edinburgh in April, if the virus does not stop everything, to talk about the implications of my English report for Scotland.

The Chair: Lord Winston, you had a quick question.

Lord Winston: My question was answered almost immediately, thank you, Lord Chairman. The point I was after was covered in the conversation with Viscount Ridley.

Q193 **Lord Kakkar:** Part of this question has been covered, but I would like to be clear about whether we have adequate data to inform our understanding about health inequalities in the UK. You have dealt with the four nations to some extent. I think you have already touched upon it, but, to be clear, which organisations collect these data?

Also, what data collection would be helpful to ensure that we can address these questions more thoroughly? How might we go about suggesting these data are collected?

Professor Sir Michael Marmot: As you know, I have been very involved in studying social determinants in health equity globally. We are almost uniquely blessed with the richness of the data that we have in this country. It is a mark of our civilisation that we have such good data. The big glaring weakness that I pointed out in my report is ethnicity. We do not routinely collect the mortality data—and, hence, the life expectancy data—by ethnicity, and it is a glaring weakness. Rightly, I got rapped over the knuckles in 2010 by colleagues representing black and ethnic minority communities. We tried to do a better job this time and we did the best we could, but it is not good enough because the data are not there.

Public Health England and the ONS do a terrific job in producing in a timely fashion the data by deprivation. The ONS published interim figures for 2019 last week. I did not know it was possible to get the data as quickly as that. One week after we scrambled to get the 2018 data into my report, they produced the 2019 data. It is quite remarkable. We get pretty good data on inequalities except for in black and ethnic minority groups, and that is a significant lack.

We have not really talked about this except in my answer to your question, but on the key issue of the social determinants of health inequalities, the data are more patchy. Again, we have uniquely good data in this country compared to most other countries, so I was able to chart the percentage of children aged five with a good level of development. We can look at GCSEs, or whatever the new scores are for young people. We can look at the proportion of young people not in employment, education or training. We can even get measures of work quality, good poverty measures and figures on problems with housing. In all the domains I looked at, we had good data.

I was in Jordan last week chairing a commission for the eastern Mediterranean region of the World Health Organization, and I showed them examples of the kinds of data that we want. I showed them, for example, the graph that indicated that the decline in spend by local government per person varied by quintile of deprivation; for local authorities in the poorest 20%, the decline in spend was 32%; and in the least deprived 20%, the decline in spend was 16%. It was neatly regressive.

I was making a point about how we need these data. Most of my colleagues from different countries in the Middle East say, "There's no way we could get data like this". That is quite apart from the clearly regressive nature of that shift in public expenditure. It is vital that we have those data alongside the health inequalities data so that we know what is going on.

Lord Kakkar: How might those data be most effectively collected and mobilised when it comes to the social determinants question?

Professor Sir Michael Marmot: We were supported in my 10 Years On review by the Health Foundation. Jennifer Dixon, its chief executive, said at the launch of our report, "Why was this not done by government? Why did a charity and a university do this? Why did government not do it?" Government should keep account of how well we are we doing. My number one recommendation was that the Prime Minister should chair a cross-government committee on health inequalities, and have a strategy and set up regular monitoring. I do not mind doing it, but I would much rather it was done routinely by government than by me.

The Chair: Has any Prime Minister ever done that?

Professor Sir Michael Marmot: Yes. When Tony Blair was elected in 1997, he invited Sir Donald Acheson to chair a committee to say what they could do to reduce health inequalities, and the Government came up with targets for reduction. They did not meet the targets, but the Blair Government came up with targets for reduction. I served on the committee that developed those targets. They missed them, but they did have a strategy to try to do something about it.

Q194 **Baroness Walmsley:** You commented earlier that in 2010 the Government accepted your report and decided that they would do things. In your view, have the Government prioritised health inequalities over the past 10 years? Who do you think is or should be responsible? Given

what you have just said, it might be the Prime Minister, but it could be somebody else. What do you think the economic and social consequences would be if health inequalities were not reduced?

Professor Sir Michael Marmot: I do not think the Government did enough over the last 10 years. They said that they welcomed my report and included in the Health and Social Care Act the fact that health authorities should have regard to the reduction of health inequalities, and I was pleased with that. But they did not do much subsequently. They had other priorities.

I talked in my report about the fact that, in 2010, public expenditure was 42% of GDP and in the latest figures it was 35%. That was clearly a priority for the Government. If you are reducing public expenditure on that scale, it is most unlikely that you are going to invest in the social determinants of health. I have just mentioned the regressive nature of the settlement for local government. We know that the need varies in proportion to the degree of deprivation, and that equal funding per person is most inequitable with respect to need. No, they did not do enough.

The good news for me was that Coventry declared itself a Marmot city. When we started working with Greater Manchester, I said, "My wife would really like you not to call yourself a Marmot region". She thinks this is malignant egomania on my part. I said, "Please, call it something else", and they said, "Too late". I asked if they would please write to my wife and explain. We have been married for 49 years, so I guess we can cope with it. There has been action at city level and regional level, much less so at national level.

Baroness Walmsley: Who do you think should be responsible?

Professor Sir Michael Marmot: That is why I said it should be the Prime Minister, because this is cross-government. Forget coronavirus just for the moment, if any of us could. This is no criticism of successive Health Ministers; they live or die by what happens to the NHS. That is what the news is about. That is what all the Questions in Parliament are about.

As I say, I briefed Ministers of Public Health, and they are expendable, they come and go, but they are the ones who should be responsible. Health Ministers have their eye on what they spend most of the money on, which is the healthcare system. We said in 2010 that 4% of the NHS budget goes on prevention. That is quite apart from investing in early child development and education. The spend on education went down by 8% per child. If you had health equity at the heart of government, you would never allow the per-child spending on education to go down by 8%. That is why I think it should be the Prime Minister. This should be a corporate issue for the whole of government.

Baroness Walmsley: What would be the economic and social consequences if this were not done?

Professor Sir Michael Marmot: I am better on the social consequences than the economic. We put some economic figures in my 2010 review. I

did not believe them. We got some tame economists to do some calculations. Economists understand money, and if you pay them they will come up with figures.

I never thought that was the argument. I thought the argument was a moral one. If we know how to get good health for the whole population, we have a moral responsibility to do it. We are—or were—the fifth richest country on the planet. If we have the scientific knowledge, the argument is a moral one. That is why I say I am better on the social consequences than the economic ones. Yes, it will cost the NHS a lot of money, and we put numbers in the report, but that is not the issue. And yes, there will be lost productivity and there will be increased crime.

If you want numbers, for every pound you spend on early child development, you save £7. I never quote Chicago economists, but Heckman says that spending on early child development is a rare example where efficiency and equity come together, because you save money by spending on early childhood. You may not save money by improving the quality of life for older people, but I think it is worth doing.

Baroness Walmsley: So do I.

Q195 **Lord Mair:** I think you have already made your views very clear about the target of five years of extra healthy living by 2035 not being all that realistic. I think that is what you believe.

I want to ask you about the various approaches that have been proposed, mainly technologies and services, to improve the lot of the ageing person. Do you think there is a danger of them exacerbating health inequalities, because it will be more affordable for the wealthier and less affordable for the poorer? Is there a danger of the technologies and services that are being contemplated and proposed making the inequality problem worse?

Professor Sir Michael Marmot: There is always that danger. In general, innovations have a big equity implication, because they tend to get taken up first by people with more education, more money and the like. I have not seen the issue as primarily technical. If the issue is not so much technical innovations in health but technical innovations in work, who is going to be affected?

The people down at the bottom are the ones who will lose their jobs. Getting rid of boring repetitive jobs seems to me quite a good thing in general, provided we make appropriate social arrangements so that the people down at the bottom do not lose out completely. Automation will not affect the people doing the skilled or strategic jobs so much, although some of my medical colleagues are concerned that they will be deskilled and replaced by robots and the like. In general, that kind of technological innovation will increase inequities and likely inequities in health. So yes, it is a real danger.

At a non-technical level, we know, for example, and there is good evidence for this, that a health education strategy in general increases inequalities. If you simply tell people what constitutes a healthy life, the

people who read the *Times* and the *Guardian* or whatever will pick it up, and those who do not, will not. That is not just because they are tuned in to information. I quoted figures from the Food Foundation in my report. If people followed Public Health England's healthy eating advice, those in the bottom 10% of household income would spend 74% of their income on eating. If you give good advice on what constitutes healthy food, people down at the bottom cannot follow that advice because they do not have enough money to do it. It is a concern that we have to have.

Lord Mair: Have you been able to take the availability of technologies into account in your studies of the statistics?

Professor Sir Michael Marmot: We have not looked at it in relation to technologies within medicine. We have been concerned about automation and those kinds of things, or digital technology. In our English longitudinal study of ageing, we showed that people who were digitally literate had better health at older ages than those who were not. Digital literacy follows the social gradient.

Q196 **Baroness Penn:** If the Prime Minister was to chair a committee on this and said, "I would like you to help me develop my strategy to reduce health inequalities. I would like to start first with my Grand Challenge target of increasing healthy life expectancy by 2035 and reducing the inequalities, and, secondly, the longer-term things we might like to do, but starting with those things", what things would you put in that strategy as the priorities for the Government to get started on?

Professor Sir Michael Marmot: I would remind him that he had another priority, which was levelling up and thinking about the deprived areas in the north of the country. He ought to put those two together. He should not think just of the average of prolonging healthy life by five years. He should think about reducing inequalities in healthy life.

I have been asked, "What do you think about HS2?" and I say, "Pass". It is not relevant to the agenda I am talking about. That will not level up. Fundamental to this is creating the conditions for people to lead lives they have reason to value. I would say to the Prime Minister that that is a worthy aim. I am not party political, but he has said that those people have lent him their vote and he wants to earn it. He should create the conditions for people in deprived communities to lead lives they have reason to value.

I can tell him some of the steps he needs to take to do that. He needs to reduce child poverty and re-open Sure Start children's centres to improve the quality of early child development. He needs to address the fact that we have this persistent social gradient in school performance and that the rate of school exclusions has gone up very dramatically, which is very bad for people down at the bottom.

I could tell him that the frequency of adverse childhood experiences increases the lower you are down the social gradient. Physical abuse, sexual abuse, psychological abuse, alcoholism, drunkenness, separation, and the like, are all more frequent the lower you are in the social

hierarchy, which damages children's lives. I would go through my report and say, "If you really want to do it, I can help you".

Baroness Penn: Not at the expense of those interventions, but thinking of the Grand Challenge mission of five years of extra healthy life expectancy by 2035, if we are saying that we will do those things in the long term because they are important, but we also want to fulfil this mission, what are the things that would help us in that timeframe and to that end?

Professor Sir Michael Marmot: First, it is a matter of simple arithmetic that if you are trying to improve the average and the inequalities are not getting smaller, or are getting bigger, it is very hard to improve to do that when it is going down for people lower down in the hierarchy.

Baroness Penn: What about the specific part of the target that is about reducing the inequalities?

Professor Sir Michael Marmot: That is vital. As I said at the beginning of the conversation, reducing child poverty per se will not meet a target in 15 years, but please do not neglect it just because you have that 15-year target. That is why I say, "Put it together with the levelling-up aspiration. Do not pursue this in isolation from that". If he asked me, that is what I would say, and I can help him because we have analysed the evidence and we have good evidence of the things that will make a difference through the life course.

It might be said that to achieve the target we should forget children and focus on older people. We know that social isolation kills older people. We should try to deal with the social arrangements that will reduce social isolation in older people. Fear of crime is one of the issues that stops older people being socially engaged, so now we are back to my joined-up agenda. We want to reduce youth crime. We know it has gone up, and we know it has gone up in deprived regions much more than in affluent regions. If we want to get elderly people socially connected, we need to invest in early childhood and adolescence and reduce crime so that elderly people do not fear crime and can get out on the streets.

Lord Patel asked me if there was an example of a previous Government doing this, and I said that there was, but we debated long and hard about numerical targets. The good side of them is that you have something to focus on. The downside is that you say, "We have this target, we have to meet it in a short period, so we will forget the longer-term agenda. We will forget young people, because that will not help us meet the target". That is the danger; it distorts the conversation.

Q197 **Baroness Young of Old Scone:** You are a great fan of local authorities which have picked up your agenda. You have said that some are leading the way. Would you either tell us or write us a note on which ones are the stars?

Professor Sir Michael Marmot: I have a very biased view about this. The stars are the ones that have approached me and said, "Can we work with you?" Coventry was the first. Greater Manchester was next. Then I

went to Chester and Mersey, and they said, "If Manchester can do it, we can". Now we are working with Chester and Mersey. There is Gateshead. I am sufficiently out of touch that I had to ask, "Do you support the same football team as the people on the other side of the river?" and they said, "Yes". I said, "You mean if we get Gateshead, we get Newcastle". They said, "Yes, probably", so Gateshead, and perhaps Newcastle. Tomorrow I am going to the Stadium of Light in Sunderland to talk about my agenda. We have a few scattered around.

Baroness Young of Old Scone: Do you have evidence from your first report flowing through into your second report of people who got it and have now taken it forward and where the figures have improved, or is there no real evidence about that yet having had an impact?

Professor Sir Michael Marmot: I met the previous deputy chair of the Bank of England at NESTA, who said, "Do you have any evidence that it works?" I said, "Not really. How would you get good evidence? There is no control group. You do not have a proper before and after". He said, "Is anybody doing it?" I said, "Coventry is doing it", and he said, "And?" I told him that they claim that more people are on a living wage, that the percentage of kids with a good level of development has improved, and that the proportion of young people not in employment, education or training has gone down, but I did not know if it would have happened anyway. He said, "That is good enough. You have proof of concept. You can't do a proper experiment, but if it is moving in the right direction that is good enough". In the "evaluation" that we have done for Coventry, the indicators are moving in the right direction, and it has been very enthusiastic about it.

I quoted in my report the example from Greater Manchester, for which I take no responsibility at all because they started it before we started working with them. Children eligible for free school meals have a lower prevalence of good early child development at age five. Greater Manchester did worse than the English average but in three years closed the gap. The proportion of children aged five with a good level of development eligible for free school meals is now at the English average in Manchester. They did it by getting well-evaluated programmes that work with families and they improved the quality of early child development for the poorest children in Manchester. We have pockets around the country that we can point to where they did good things and good things happened. I am cautious as an academic to say we have proved causation, but we have examples where things are moving in the right direction.

Q198 **Lord Browne of Ladyton:** Since the publication of your report, have you met with or been approached by, or do you plan to meet with, any Ministers to discuss this report? In particular, have you been contacted by the Treasury before today's levelling-up Budget?

Professor Sir Michael Marmot: I have not been approached by any Ministers. I am perfectly happy to talk to Ministers, as I implied earlier. I would be perfectly happy to talk to the Prime Minister. I met the Prime Minister's health adviser, at his invitation, before my report was

published. He asked me to come and see him, which I did. He had wanted his equivalent at the Treasury to join the meeting, but his equivalent at the Treasury got sacked a few days before the meeting, for reasons that you will know about—because he was an adviser to the previous Chancellor—so I was going to meet a special adviser to the Treasury, but he lost his job.

So no, no Minister has approached me since my report has been published, but I am perfectly open to talking to people in government. That is why we did it. We want the Government to take action.

Lord Browne of Ladyton: You will be aware that there are officials in the Treasury who have responsibility for health spending. You have not been in touch with any of them.

Professor Sir Michael Marmot: No. Just to repeat, usually when they talk about health spending they mean spending on the National Health Service. I am talking about spending on social conditions to improve health, which is not quite the same thing.

Lord Browne of Ladyton: I understand. I was only in the Treasury for a very short period, but it has people who focus on public health. It may not manifest very clearly in the way in which the money is spent, but it does have people who do that.

The Chair: What influence do you think the inequality commission has?

Professor Sir Michael Marmot: Do you mean the existing Equality and Human Rights Commission?

The Chair: Yes.

Professor Sir Michael Marmot: My understanding is that they do not gather data of the kind that fill my report. I told you that I was nervous about the big lack in our report of data on ethnic differences, and somebody who was in touch with us said, "It is okay, you did fine", but any possibility of improving the data collection to represent ethnic differences—this relates to Lord Kakkar's question—would be very welcome.

The Chair: Sir Michael, I have slightly overshot with time. I hope that does not mean you have to rush even more. Thank you very much indeed for coming and for a whole load of good information.