

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Thursday 2 July 2020

4 pm

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Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

Evidence Session No. 10

Virtual Proceeding

Questions 66 - 69

Witnesses

I: Professor Sir Michael Marmot, Director, UCL Institute of Health Equity; James Bullion, President, Association of Directors of Adult Social Services, and Executive Director of Adult Social Services, Norfolk County Council; Chris Naylor, Senior Fellow, The King's Fund.

Examination of witnesses

Sir Michael Marmot, James Bullion and Chris Naylor.

The Chair: In this session we will explore in particular issues around place and people with protected characteristics. We are very pleased to welcome Professor Sir Michael Marmot. Your 2020 report came out just as we were all convened as a Committee, so yours was the first bit of work that staff presented to us to look at to think about what we were going to do. We have James Bullion, president of ADASS, and Chris Naylor, a senior fellow at The King's Fund. When you answer your first question, could you say who you are and where you are from so that the public in particular know who is answering questions?

Q66 Baroness Pitkeathley: It is indeed an honour to have these witnesses before us this afternoon. My question is about health inequalities, so you will not be surprised, Sir Michael, that I turn to you first. We are looking at place now. In the previous session, we talked about inequalities among communities. Why are some places healthier than others, and what have the consequences of those health inequalities been during this

coronavirus outbreak?

Sir Michael Marmot: I am director of the Institute of Health Equity at UCL. We use place in two ways. One is as a proxy for individual characteristics. The Office for National Statistics has an index of multiple deprivation, and we can describe neighbourhoods on that scale. We see a social gradient; the more deprived the area, the higher the mortality, which is very similar to the social gradient we would see if we described individuals by their years of education, their income and their occupation status. We use the index of multiple deprivation of the place because we can get it readily; ONS publishes it on a regular basis, and it is very helpful as a proxy. I will say a word about black, Asian and minority ethnic groups a bit later.

Then the question is: what about the place itself? In my 2020 report, which you saw in February, we showed that for people in the least deprived 10% of local authorities the regional difference in the country was quite small. The more deprived the area of residence, the greater the difference region made. When we look at the bottom 10%, the most deprived 10%, there are huge regional differences. As I am sure you know, we showed that life expectancy for women in the most deprived 10% went up in London, but down in most regions outside London. The fact that it is worse to be in a similar level of deprivation in the north-east and the north-west than it is in London and the south-east is challenging.

Whether it is a proxy for individual characteristics or whether it is telling us something about place is a challenging question. I would like to say that I absolutely know the answer, but I do not; I have been struggling with it for years, and I will keep struggling with it. We think we can get part of the way to an answer in more deprived areas, as we showed in our report. Take spending by local authorities. In the nine years since 2010-11, spending by local authorities went down by 16% in the least deprived 20% of areas and went down by 32% in the most deprived 20% of areas, so you have an intersection with taking away finances for local services in the more deprived areas, which tend to be in the north-east and north-west, not in the south-east.

Having confessed that I do not know the answer, I can now say anything I like. Stripping back local government expenditure in the more deprived areas is likely to have made a huge difference. We know that 1,000 Sure Start children's centres closed. We know that funding for youth groups went down. We know that adult social care funding went down more in deprived areas than in less deprived areas. Funding for everything at local level went down, the more deprived the area. We have real evidence that shows that things happen at the place level that could plausibly account for the health inequalities we see between places.

Baroness Pitkeathley: What are the particular consequences of that during this outbreak?

Sir Michael Marmot: I said at the beginning of the outbreak, when people were saying that it was the great leveller, that it was not. If a

prince and a pauper, Tom Hanks, a football manager and a Prime Minister can be affected, it sounds like the great leveller, but no way. Absolutely not. As soon as we started to get data, we saw what I was concerned about, which was that the pandemic would expose the underlying inequalities in society and amplify them. That is what we have seen.

ONS has been brilliant. Let me give a big shout to ONS and Public Health England. I can scarcely keep up with ONS, and I am a data nerd. ONS has been putting out a whole string of publications on the effect of the pandemic. What is interesting to me is that, in both England and Scotland, the social gradient in mortality from Covid-19 almost exactly parallels the social gradient in mortality from all causes that I described in my 2020 report, with the slight difference that the excess of Covid-19 in the most deprived two deciles is a bit higher than for all causes.

That suggests to me that our understanding of the causes of health inequalities more generally applies to Covid-19, only a bit more so. Why would it be higher in the bottom two deciles? We know that people in front-line occupations who have to go out to work are exposed—key workers such as drivers, care workers, shop assistants in supermarkets and food packers. People in key occupations who tend to be the poorest were having to go out to work. It is also likely to relate to crowding, where people are living perhaps in multigenerational overcrowded households.

The effect of Covid-19 has been to exaggerate the inequalities. As you know very well, ONS published a report before the pandemic showing that more than half the workers employed in communications said they could work from home, whereas only 10% of workers employed in the hospitality industry said they could work from home. Then we had the shutdown, and workers in hospitality either lost their jobs or were on furlough. A few of them were still going out to work. If they are on the government furlough scheme, they will get some drop in income, but communication workers can keep working from home. Recent figures show that wealth increased in the wealthier subgroups of the population and went down in the poorest subgroups, as people spent down their savings to make up for the gap in income. The effect of the pandemic is to exaggerate inequalities.

Baroness Pitkeathley: James, will you give us your take on the consequences of the health inequalities?

James Bullion: I am president of ADASS, the Association of Directors of Adult Social Services. I represent 152 directors in England, and during the day I am a jobbing director in Norfolk.

Place is incredibly important to the way adult social care and social work is done. Often, health inequalities, or inequalities of outcome, for people with social care needs are determined as much by the wider determinants of a person's health as they are by the particular disease or disability they are experiencing. From a local authority point of view, Covid-19 has been a bit of a thunderclap reminder that local authorities have a wider

job on place to try to connect and pull people together, working around either vulnerability or in communities themselves. We work in place because we have to work on those wider determinants, and that means agencies working together, with adult social care working with housing and with health and voluntary groups.

Our experience of Covid-19 is that, because adult social care and the NHS have had differential priority both in policy and in funding, over the past five to seven years we have seen budget constraints. We attempted to deal with the pandemic against that background. Our recent survey of social services directors showed that we were more concerned about our ability to meet our statutory duties under our legislation, the Care Act, which means that over the past few years we have seen a reduction in our preventive spending. That reflects Sir Michael's points.

In an area where there are health inequalities, or where you need to act disproportionately to address such inequalities, and local authority social services are under a finance constraint, the first thing that goes is the ability to work preventively, alongside an NHS that is increasingly place-based and increasingly working preventively. One of our rueful observations in adult social care is that the NHS plan is good, place-based work and starts to try to address through primary and community care an ability to take a population-level approach to an area, just at a time when, although local government feels it probably has the intellectual willingness and certainly the ability to work on preventive models, it is without the resources. I suspect that is some of the reason why there are disproportionately higher reductions in the most deprived areas. They may have been where local authorities were doing more preventive work in the past, so there is a combination of unmet needs rising in places where inequalities already exist.

Our recent survey of directors showed that in half of our places in England we have seen unmet needs rise significantly, and they have risen even further during the pandemic. The impact of the pandemic on people has been twofold. It seems to us that it has affected and led to the death of more people at disadvantage, both service users and care workers themselves. We have a care workforce that is underpaid and undervalued, with a significant presence of BAME and European workers in particular.

Covid has had an impact on people's individual lives as well as their lives in a place, as it were. Those are the normal impacts you would expect: service disruption, service closures, the changed nature of service delivery because of PPE, and infection control. To some degree, those already at a disadvantage, such as rough sleepers, homeless people or prisoners, are disproportionately impacted, with very poor outcomes.

Chris Naylor: Thank you all for the opportunity to be with you this afternoon. I am a senior fellow at the King's Fund. We are an independent health charity that works to improve health and care in England.

Perhaps I could start with the state of play going into the crisis. Comparing different parts of the country, there were huge variations in rates of respiratory conditions, heart conditions, diabetes and other conditions. What we have seen from the data during the Covid pandemic is that all those conditions increase people's vulnerability to the virus. I would exactly echo the language Sir Michael used earlier. Covid has both exposed the inequalities that we already have in our country and amplified them, because the particular characteristics of the disease mean that, even more than other health conditions, it disproportionately affects people in the more deprived parts of the country.

Why do we have these huge inequalities between different places? The biggest factors are the ones we have already heard about: economic circumstances, job opportunities and the environmental and social conditions in the place where we live, and what all those things mean for the options available to us in our lives.

One thing I want to stress is that knowing that these inequalities are caused in large part by wider social determinants does not mean we should conclude that the NHS and health services have no role to play in tackling them. Depending on which research you look at, access to healthcare accounts for perhaps 10% to 20% of the variation in the health outcomes of different populations. It is only 10% to 20%, but that is still quite a big chunk. The NHS can play a huge role in tackling health inequalities both in its role as a provider of health services and because it is one of the biggest employers in the country, and one of the biggest economic actors in the country through its purchasing power and so on. It can use that broader power to help address inequalities in health.

It is important to recognise that some of the place-based inequalities we talk about happen at a very local level. We are all very accustomed to comparing the north of England with the south, or east London with west London, or looking at one local authority area compared with another. If we zoom in a bit, and take the example of two neighbouring areas of Clapham in south London that are directly adjacent to each other, the gap in healthy life expectancy for men is 12 years and for women it is seven years. I mention that, because it is important to recognise that you do not necessarily have to travel to a different part of the country to see place-based inequalities in action; sometimes it is enough to cross the street.

Lord Hunt of Kings Heath: We heard mention of the NHS plan and the fact that, probably more than any other NHS policy paper, it reflects place and the role of prevention, but it seems to me that the lesson about the health service in the last four months has been lack of capacity. There is also a huge catch-up agenda for people with health conditions and opportunities for treatment. I wonder whether our witnesses feel that because of the lack of capacity it will derail the intention of the plan.

The Chair: You need to repeat that last sentence.

Lord Hunt of Kings Heath: The NHS plan has a lot of support; it is

facing in the right direction, but there is clearly a risk that the huge capacity agenda for the health service will to derail it. I wonder whether our witnesses could help us to see whether there was a way through in dealing with what is likely to be quite a tension over the next year or two.

Chris Naylor: Lord Hunt is right to say that the long-term plan NHS England has published acknowledges the role of working in a more place-based way, and talks about local NHS organisations needing to work more closely with local authorities, voluntary sector partners and others. We believe that that direction of travel is fundamentally the right one.

If there is something that could derail it, it is the workforce situation. We went into the Covid pandemic with over 40,000 nursing vacancies across England; one in eight nursing posts across the NHS was lying vacant. There were also significant shortages in primary care, mental health, social care and a number of other areas. Covid has meant that we have developed a backlog of work across the NHS that will now add to the pressures on that already overstretched workforce. If there is one thing we need to prioritise in policy over the coming months, it is the need for rapid thinking about tackling the workforce crisis in the NHS and social care.

Sir Michael Marmot: I do not think there was enough on the social determinants of health in the long-term plan. There is some mention of working with others, which is important, but that is alongside the kind of vacancies and relative underfunding of the health service that we heard about a moment ago, so we are not embracing the opportunities.

As Chris said, the health service accounts for between 10% and 20% of the health of the population, and that could be enhanced because the healthcare system could be doing more to address the conditions in which people live. It may be by working in partnership. The opening line of my book *The Health Gap* is, "Why treat people and send them back to the conditions that made them sick?" The Covid-19 pandemic has exposed that to a much greater degree. I would have liked to see in the long-term plan much more focus on the social determinants of health and what the healthcare system can do to address them.

James Bullion: In some ways, the challenge for the NHS in particular is that, because it does not have people working on those wider determinants and taking preventive action among the partnerships that surround it in a place, it feels that it has to encroach more and more, particularly through GPs, who are extremely stretched. We do not have enough of them and we are not likely to meet some of the recruitment targets set in the plan. There needs to be investment alongside the NHS to enable the plan to be delivered.

There are some quite positive signs that Covid has rapidly accelerated the partnerships on discharge and admission avoidance in a community. Some elements of the NHS plan that were in year four—for example, the Ageing Well programme—have rapidly sped up as a result of Covid. If we are brave and bring that investment forward from year four to now, there

are prospects of doing some interesting work with the clinical leads of the primary care networks, taking a population health management approach and trying to work on some of the wider determinants.

I absolutely agree with Chris that workforce is a major constraint. Nurses in social care are at a premium. About 11% of them are from Europe; for example, in my area, Great Yarmouth, 50% of the nurses in social care are from eastern Europe. There are very high levels of vacancies and turnover, and it is a very uncertain time for them. Clearly, workforce is one huge stumbling block that we will have to address, but I am optimistic about the NHS plan as long as we break it up a bit and perhaps localise it a little more.

Q67 Baroness Tyler of Enfield: James, building on the things you said a bit earlier, to what extent have areas that developed a real place-based approach to services been better able to respond to the crisis than other areas? Do you have any examples of ones that did particularly well or badly? I have a slightly more specific question for Sir Michael afterwards.

James Bullion: Where local authorities have existing partnerships, there are good examples of those taking on the challenge of Covid-19, and the challenge of inequalities and, to some degree, dealing with specific BAME issues. My colleagues in Birmingham had the Birmingham HIVE model, which was a pre-existing way of connecting people with services. That could be deployed very quickly to deal with issues of clinically extremely vulnerable people. It had eyes and ears.

As you can imagine, during Covid, as services closed and were locked down, there were increased worries about safeguarding and lack of referrals around domestic abuse. Where a community organisation knows its community, you have much more chance to try to intervene. There are examples like that dotted around.

Since the demise of initiatives such as Supporting People, which brought people together around a housing agenda locally, and as the infrastructure for locality working in local government has been pared back since 2009, those are increasingly the subject of local innovation rather than a framework. One of the reflections we need as a result of Covid is whether the local and national framework for local government is quite right now. When we need consistency and a pattern of investment, do we have the infrastructure to do that now?

Baroness Tyler of Enfield: Sir Michael, building on things you said a bit earlier, how easy do you feel it is to knit together place-based approaches with overall strategies for tackling health inequalities? Do you feel that place needs to happen primarily at local level, or is there also a national dimension?

Sir Michael Marmot: The easy answer is yes, both. We have been working with Coventry, which declared itself a Marmot city. Latterly, we have been working with Greater Manchester, which said that it wanted to be a Marmot region.

Let me say something that is probably politically incorrect. Forgive me. My experience of working at local level with local government is that it matters much less which political party the local politicians come from. Whichever party they come from, they understand a great deal about the conditions in which people are born, grow up, live, work and age. That is what they do, so they really experience it. I am not saying that political party is unimportant at the local level, but it is a good deal less important at that level, in my experience, than it is at national level.

When we worked with Coventry, they took the six recommendations from my 2010 review, five of which we looked at again in the 2020 review, and said, "This is our basis for planning to make Coventry a healthier place to be". Similarly, Greater Manchester took it on. We got slightly interrupted by Covid-19, so we changed the focus of our work with Greater Manchester to be about the impact of Covid-19 on inequalities and then building back better.

That said, what happens at national level is very important. We have been talking about social care. I talked about general funding to local authorities. Let us look at adult social care spending, to build on what James has been saying. For the least deprived 20% of local authorities, spending on adult social care went down by 3% over the 10 years of my 2020 review, and in the most deprived 20% it went down by 16%. That has been set by central government, and there is only so much that can be done at city level to counteract it. The rise in child poverty is set by fiscal change, in changes to the tax and benefits system at central government level. There is only so much that local authorities can do to counteract that, but there is a great deal that can be done at local level.

While I am on the decline in spending on adult social care, and I presume James will agree with me, we have been, rightly, hugely distressed by Covid-19 in care homes. Let us look at workers in care homes. If they are paid the minimum wage, they are lucky; many are not. Their conditions of work are terrible; they have very poor job prospects. I have been arguing that for early childhood we need a skilled, educated workforce. Working with young children should be a skilled job and highly important.

I feel the same way about working with older people in need. We should not pay people a miserable wage and give them rotten conditions of work. We are making them almost like Typhoid Mary; we push them around from one care home to another without testing them and giving them PPE, and helping them to spread the virus. We need a properly skilled workforce, with good conditions of work and good future prospects, working in care homes and adult social care more generally. That can be done at city level and local level, but it needs support from central government.

Q68 Lord Young of Cookham: I thought the last contribution from Sir Michael was particularly valuable. A few weeks ago, we had before us as a witness Jeanelle de Gruchy from the Association of Directors of Public Health. She said that the response to the pandemic had been an NHS response, not a public health response. What would a public health

response have looked like for the deprived groups and communities we have been talking about this afternoon? Just standing back a bit, did we get Public Health England and the directors of public health right in the 2012 reforms, or do we need to have another look at the whole structure as a result of the pandemic?

Sir Michael Marmot: Jeanelle de Gruchy is much more informed and skilled on this question than I can be. One of the things we did to public health was not just move it into local government, which is an opportunity as well as a threat, but reduced the funding. Many of my public health colleagues have said, "Give us the capacity at local level to institute testing, tracing and isolating. That is a traditional public health function. We will do it, but we do not have the capacity to do it because funding was stripped away".

I do not know that we got the model wrong with Public Health England and putting public health in local government. We got the funding wrong; we stripped away the funding and the capacity to do traditional infectious disease outbreak public health activities at local level.

James Bullion: I can only echo what Sir Michael said. A public health response would have been pre-existing to some degree. In a pandemic, you necessarily have to be reactive and make sure that you have a service response that can cope with the hospital situation, and the infection control and protection situation. A lot of funding for preventive approaches, and indeed education, would have been pre-existing, and education is knowing what health creation looks like, so that you are both personally and in a community resilient to a range of poor health outcomes, not just the pandemic; every year, we have flu and other health situations that need responding to.

I celebrate public health being in local government; I feel it has come home to where we have a community-based response. However, one reflection is that, if public health is the evidence base for things such as how we tackle inequalities, the challenge is whether everyone is listening to public health locally. I am being polite. I probably mean, "Is the NHS listening to public health?" I sometimes feel that, in the NHS plan, population health management might have been invented as an alternative to public health in the NHS, rather than a proper integration between public health in local government and our NHS colleagues. That is slightly controversial, but that is my feeling.

The Chair: You are absolutely allowed to be controversial.

Chris Naylor: On the arrangements for public health created under the 2012 Act, I agree with the other speakers. Local authorities are the right place for public health, and if you survey directors of public health, a large majority of them say that. Embedding public health in local authorities means that they have a much broader set of levers at their disposal to tackle the social determinants of health we have been talking about.

At the level of Public Health England as a national body, there has been some discussion in the media about whether we need to bring PHE back under closer ministerial control. It is important to be clear what PHE is. It is not like NHS England. NHS England is a quasi-independent organisation. Public Health England is not; it is an executive agency of the Department of Health and Social Care and is already under direct ministerial control. It is quite clear that the department needs some kind of public health function, and if we were to abolish Public Health England, my concern is that it would simply need to be reincarnated under a different name. That is unlikely to be helpful, particularly as the country is going through a major public health crisis.

On the question of what a public health response to Covid would look like, there are things that we need to pay some attention to as we go into possible further waves of the pandemic. We have seen some excellent examples of joint working and collaboration between the NHS and local government throughout the crisis. Indeed, in some ways the crisis has accelerated that integrated working in many parts of the country. My observation would be that it is very variable in different places, and the relationship between the NHS and local government is not consistent across the country. That is where we need more focus going forward.

Q69 Baroness Wyld: This has been enormously helpful. I have a prepared question, but I want to follow up on the wider discussion. Perhaps we can drill down a bit into place and talk a bit more about people. Pre-Covid, I sat on the Select Committee on Regenerating Seaside Towns and Communities. We saw some good community-led examples of public health improvement; there was a particularly innovative GP in one area. I am sure all of you will have seen such examples. The question is how you scale them up and replicate them. Any insights you have on that would be hugely helpful.

While you are thinking about that, my prepared question is this. If you were to be granted one intervention by central government, given that government is full of hard choices, which one would you go for?

Sir Michael Marmot: It relates to a broader issue. Do you take a great person view of history or a structural view of history? As I said in response to an earlier question, the answer is surely both. My experience of what happens at local level is that, where you have a charismatic local government chief executive or, in the case of Greater Manchester, the Mayor of Greater Manchester, who is well supported not just by public health but across the whole city or local government, things happen; but public health on its own cannot do it.

As colleagues have said, and as I said before, to have public health in local government is an opportunity, but you need strong commitment from the centre of city government—the mayor, the chief executive or the leader of the council—and charismatic, skilled and effective public health. My experience in Coventry, Gateshead, Greater Manchester, Chester and Merseyside is that they have that. Public health is very

effective and communicates well with the leaders of the council, and then it really works.

To scale up, as we have all been saying, needs money; it needs to be properly funded. Getting that right relates to your prepared question. I am usually a bit mischievous when somebody asks me what the one thing I would recommend is. I say, "Well, I recommended five things in my report, so the one thing is: read my report". The No. 1 recommendation in my 2020 report was that the Prime Minister should chair a cross-government strategy for the reduction of health inequalities.

The one thing, just as I have been saying at the city level, is that we want the Prime Minister, the head of the Government, to lead a cross-government strategy, with reduction of health inequalities as the outcome. That means housing, education, early childhood, jobs and transport—all those things—so I am not going to pick which one is the most important. The most important thing is that it should come from the centre, from the Prime Minister leading a cross-government strategy.

Baroness Wyld: I would not disagree with that. I read your report. It is a very good challenge.

James Bullion: It is an incredibly hard question, or two questions. I suppose that if I had to diagnose what I have experienced in social care and local government over the past 10 years, it has been a series of short-termist viewpoints coming from Governments and a series of either reorganisations or particular changes and failure to follow through. The Care Act is a good functional piece of law, but it has suffered from lack of implementation.

One of the strengths of localism, local government and place work is that some institutions can take a very long-term view. With housing, for example, we can get local authorities to take a 30-year view. On social services, the image in most people's minds is of social workers working with older people for a few years at the end of life, but half of social work these days is working with younger people for 30 or 40 years, or even 50 years given life expectancy, and long may it continue.

If I could have one intervention, it would be a really long-term devolution to solve inequality at local level consistently for a good 30 years. I know that is practically impossible to achieve politically, but unless we break the short-termism in social care, in local government in particular, we cannot advance some of the underlying progressions that we need.

Chris Naylor: One thing to improve health inequality would be to give it the push that it deserves across Whitehall. I concur with Sir Michael. We need a cross-departmental health inequalities strategy with ambitious goals. Those goals need to be monitored robustly over time, and individual departments need to be held accountable for their performance against those goals. It has to be cross-departmental, because the Department of Health and Social Care, or any other single department, cannot tackle that agenda on its own. The evidence we have from

research is that when we have taken such cross-departmental approaches in the past they have delivered results, so let us build on that.

The question about scaling up when we see things working in some parts of the country is difficult, because things are so contextual and the local history of a place matters. We did some work in Wigan last year. Wigan is a great example of an area that has been trying to work differently with local people, investing in grass-roots community organisations and building community leadership. It has attracted a lot of attention across other parts of the country.

The danger is that people think it is a kind of drag and drop; they look at the model Wigan has developed and think, "Let's do that here". Nine times out of ten that does not work because of the local context. The thing you can transfer is not necessarily the precise approach or model; it is the idea of starting with a clear set of principles that bind together the different public agencies working in a place, and then working together on those principles determinedly and consistently over time. The risk is always that the latest thing from national government or from NHS bodies can deflect that kind of consistent local purpose, and we need to make sure that it does not.

The Chair: Chris, do I take it from what you have just said about the sort of approach that has been taken in Wigan—and I would add Oldham, as another Greater Manchester area—is that they were more prepared in their response because they were already working in that very different way? Were they better able to respond to coronavirus?

Chris Naylor: I cannot answer that in relation to Wigan specifically, because I have not seen data for Wigan. In parts of the country where they have invested a lot of time in working in a place-based way, building relationships across different agencies, we certainly see some good examples of how they built on that during the Covid pandemic, and worked together as a system to try to navigate through it.

The Chair: Unfortunately, we have just about come to the end of our session. Do any of the witnesses want to say anything else? We have a couple of minutes.

Sir Michael Marmot: I want to put the discussion in context. Personally, I am finding it very important. My previous discussion this afternoon, half an hour before this one started, was about a new globally sustainable health equity initiative. I do not know where in the world we were, because we are now all virtual, but it was billed as being in Geneva.

I spoke at it representing the World Medical Association. Dr Tedros represented the World Health Organization, and Michelle Bachelet spoke as the UN Commissioner for Human Rights. What both Tedros and Michelle Bachelet said was very similar to what we have been saying to you this afternoon, which is that Covid-19 has exaggerated the inequalities in society. As we look at building back better, we have to deal

with health equity and sustainability at the same time. They did not say local and central; that was not part of what they were saying, but the thrust of what Tedros and Michelle Bachelet said was about looking at the equity impact, recognising the catastrophic effect on the poor and disadvantaged, and why that has to be fundamental to how we build back better. This conversation, which I think is terribly important, is highly germane to that global context.

The Chair: It is very important to remind ourselves that we are part of a world where everyone is having to tackle inequalities in the midst of dealing with the pandemic and seeing what it is doing to different organisations.

I thank all three witnesses. We are really grateful to you. It has been a very challenging and thought-provoking session, to put it mildly. I hope you will feel that our report reflects the value of the contribution you have made. If there is anything else you want to say to us in the weeks to come, please let us know, and please let us have anything you might be writing or thinking about it in the future. Thank you all very much and our thanks to everybody who has been with us this afternoon.