Challenges facing a Secretary of State *for* Health

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The clue is in the title: Secretary of State *for* Health. The task for a new senior health minister in England is daunting: the nation's health is poor and marked by large inequalities.(1) It was poor pre-pandemic and our handling of the pandemic made it worse. In England, as in most countries, health is much better in the 2020s than, say, in the 1920s. But that is not the most telling comparison. Where could we be, nay where should we be, with respect to the nation's health now. One way to make that judgement is comparison with other countries. Three indicators, pre-pandemic, show the extent of the challenge. In 2019, child mortality in England ranked 22 out of 23 "western" European countries;(2) on child well-being at age 15, the UK ranked 27 out of 38 rich (OECD) countries;(3) in the decade after 2010, improvement in life expectancy was nearly the slowest of any rich country.(1) Cold comfort: on each of these three measures the US performed worse than the UK.

The other way to make a judgement on the nation's health is the extent of inequalities in each of these three indicators. During the decade after 2010, health inequalities increased, and life expectancy actually declined for people living in the most deprived decile of areas outside London.(1) Infant and child deaths show a steep social gradient – if the infant mortality rates of the most deprived 80% of the population, were to go down to the more acceptable levels of the least deprived 20%, half of infant deaths would be prevented.(2) A potent predictor of child well-being is degree of deprivation.(3) If health is not improving and health inequalities are getting worse, it is an indicator that society is not improving and is becoming more unequal.

A conventional view of the challenges for the new health secretary focuses on the health care system: those posed by the virulent Delta strain of the virus responsible for COVID-19; a backlog of operations and risks of untreated cancer patients; a potential flu epidemic with strains on the care system; an exhausted health care workforce; appointing a new chief executive of the NHS; a white paper on (yet again) NHS reorganisation; recognising there is no longer a carpet big enough under which to sweep the unsolved crisis in adult social care that puts strain on the NHS.

All significant challenges, but a secretary *for* health has to have responsibility for health not just health care and social care. And the key determinants of health, and of health inequalities, lie outside the health and care system. In our 2010 Marmot Review we emphasised the importance of six domains: early child development, education, employment and working conditions, having enough money to lead a healthy life, healthy and sustainable communities, and taking a social determinants of health approach to healthy behaviours.(4) These have all been under threat in the decade beginning in 2010 –

the decade when governments, of which the new health secretary was latterly a minister, pursued policies of austerity.

In our *Build Back Fairer* report, we noted that inequalities in health, now including a social gradient in COVID-19 mortality and ethnic inequalities, were amplified by the pandemic.(5) Added to inequalities, and perhaps linked, the UK had the highest excess mortality of any country in the first half year of the pandemic. We suggested four ways that the poor state of health pre-pandemic and poor handling of the pandemic could be linked: quality of governance and political culture; increased social and economic inequalities; disinvestment in public services; and the country was not very healthy.

In this context, by good governance, we mean putting equity of health and well-being at the heart of all government policy. It has to be the prime focus of the present government if it is serious about levelling up. By contrast, the UK government elected in 2010 had rolling back of the state, austerity, as its central mission. It was quite successful in that mission, public sector expenditure went down from 42% of GDP in 2009/2010 to 35% by 2018/19, and cuts to local government expenditure were made in a sharply regressive manner, the poorer the area the steeper the cuts – a 32% reduction is spending per person in the most deprived quintile of local areas. Plausibly, the cost of that "success" was the failure of health to continue to improve at its historic rate, the increase in health inequalities, and health for the poorest people getting worse. When the new health secretary left the Treasury he expressed regret that he had not been there to enact further tax cuts. Why? Would that have improved health and reduced health inequalities? A different approach is provided by the New Zealand Treasury whose stated mission, pre-pandemic was to put well-being at the heart of government policy. (https://www.treasury.govt.nz/information-and-services/nz-economy/higher-living-standards/our-living-standards-framework)

If the incumbent is to fulfil the role of secretary *for* health, he must be the advocate for policies to improve health and reduce inequalities right across government. It is he, or she, that should be held to account when there is failure in the fundamental responsibility of government: to create the conditions for greater equity of health and well-being of the population.

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