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PRIORITY SETTING FOR HEALTH EQUALITY – SEARCHING FOR AN ETHICAL FRAMEWORK

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Abstract:

Compounded by 14 years of public welfare austerity, health equality presents a challenge that extends beyond healthcare in isolation because it also engages the more recondite politics of public health. Recent policy has addressed the issue by requiring NHS bodies to integrate their services with those of local authorities. We consider how this adds significant new difficulty to the already complex process of NHS resource allocation. We argue that these duties require a new framework to gauge the values, evidence and criteria needed to set priorities for public health; not simply as a desirable objective, but a necessity in law. We consider current approaches to priority setting for medical treatment, and the responses already offered by current ethical frameworks. We then discuss the new ethical, political, and practical challenges posed by public health priority setting for health equality. Informed by this context, we engage an intersectional lens to explore a 'non-ideal' solution grounded in Professor Sir Michael Marmot's framework to reduce health inequalities.

Introduction

NHS resource allocation has never been easy, but it is becoming increasingly challenging. One immediate difficulty concerns managing competing priorities for treatment following "the most austere decade since the NHS was founded…" (DHSC, 2024 (a); See also, Hernandez, 2021; NHS Confederation (a), 2023; Harker, 2019; Stoye et al., 2024). Still more difficult, however, are the new statutory duties in England about reducing health inequality. This is the issue we address here.

Health inequality reflects economic inequalities, particularly, poverty (Institute for Fiscal Studies, 2024). The chronic diseases treated by the NHS do not simply rise from patients struck at random. Instead, they are often predicted by the social and commercial determinants of health (Mindell et al., 2014; Schrecker and Bambra, 2015). “Poor health is strongly associated with living in socioeconomically deprived areas. A girl born today in the most deprived 10% of local areas is expected to live 20 fewer years in good health than a girl born in the least deprived.” (Finch et al., 2024). Previously, concerns about inequality were not the primary responsibility of the NHS. For example, the inequalities of underprivileged children, poor housing and homelessness fell to local authorities.[1] Today that has changed. Since 2012, NHS bodies in England have had a duty, restated by the Health and Care Act 2022, to “have regard to the need to reduce health inequalities between persons” as to both their ability to access care and the outcomes achieved for them,[2] by integrating their services with those of local authorities.

Given the immensity of the challenge, we urgently need a framework to determine how to perform these new duties. ~~Given the immensity of the challenge, how should these new duties be performed?~~ As Dorling has said: “The UK is now very likely to be the most economically unequal country in Europe… the most expensive and poorest-quality housing, the most precarious and often lowest-paying work for so many people, the lowest state pension and the stingiest welfare benefits [and] the sharpest declines in health… especially of its children” (Dorling, 2023). Ideally, therefore, appropriate public health responses should be identified within a clear framework of ethical values, determined by appropriate stakeholders and guided by robust evidence and well-defined criteria. However, the practical implementation of such an approach presents a challenge. Within what set of ethical values should such a framework be constructed, by whom, and subject to what evidence and criteria? For example, we may disagree whether to assign priorities to the effects of the physical environment (such as the dangers arising from air and water quality, sanitation, and poor housing); the social and economic determinants of health, (e.g. education, housing, employment, race, gender and welfare support); ready access to healthcare; or to unhealthy behaviours (such as diet and exercise, and the use tobacco, alcohol and drugs).~~?~~ How should factors like these be prioritised, measured and compared?

We consider: (A) the current approaches to NHS priority setting for medical treatments in England and explain the helpful response of ethical frameworks. We then discuss more broadly (B) the significant new ethical, political and practical challenges posed by public health priority-setting to address health inequality. (C) We highlight the advantages of an intersectional perspective to assist the formulation of an ethical approach which addresses the root causes of health inequalities. Finally, in the absence of workable guidance from the centre, we discuss (D) a 'non-ideal' solution, grounded in Professor Sir Michael Marmot's pragmatic approach to tackling health inequality in England.

A. NHS Priority Setting for Treatments – Current Approaches

Priority setting is familiar to NHS health authorities. In respect of medicines, local recommendations to commission NHS treatments still fall to health authorities (currently integrated care boards (ICBs)). Priority setting requires health authorities to comply with the NHS Constitution and, therefore, to explain their decision-making.[3] Many appoint 'priorities committees' or 'medicines optimisation committees' to assist them, guided by ethical frameworks of principles to take decisions and explain their reasons. For example, in common with many others, the South East Region health authorities engage an Ethical Framework which sets down a small number of general statements to guide decision-making, referring to principles such as equality, costs of treatment and opportunity costs, quality of clinical evidence and exceptional need.[4] Requests for funding for new treatments may be submitted by doctors, pharmacists, hospitals and health authorities based on their experiences of need within the local NHS. New treatment applications are assessed by reference to an ethical framework as a way of promoting fairness, consistency and transparency in decision-making (Newdick (a), 2016; Newdick, 2014).

Priorities committees offer advice only to ICBs and may also recommend not to commission a treatment, for example, because it is unaffordable within the local NHS or the evidence of efficacy is unpersuasive. Health authorities may, therefore, decide not to support the treatment except in cases of exceptional need. Of course, this is not an exact science and disagreements can arise between decision-makers. Nevertheless, certain components of the process are reasonably well-understood. Aside from these ethical principles, the focus is on the benefit to be gained from the 'treatment' of 'patients' by use of 'healthcare' having regard to the best clinical trials evidence and the impact of the costs of purchase on a finite budget (including reference to QALYs). These ethical frameworks are an impartial starting point, a neutral explanatory tool against which applications are tested and assessed.

Decision-making tools of this nature are not simply desirable. They are essential to enable health authorities to demonstrate qualities vital in the law of judicial review, especially that policymaking is rational and proportionate. Frameworks of this nature assist fairness and consistency in decision-making. ~~Otherwise, how could we be reassured thatwe may not be able to guarantee decision-making is that respondsing fairly, equally and consistently to local need, rather and may simply be than being piecemeal and chaotic.?~~ As a process for responding to patients (and judicial review), these frameworks have been reasonably effective. Crucially, however, they have not created substantive rights for patients, i.e. rights of access to particular care and treatment. They do no more than establish a model of procedural rights which seek to guarantee the ideal of a fair, equal and consistent process for decision-making, often referred to as "accountability for reasonableness" (Daniels, 2008).

B. Health Inequality Priority Setting – the New Challenge

If this process has been helpful in relation to the allocation of resources for medicines to treat patients after they have fallen ill, to what extent is it relevant to measures concerned to reduce health inequalities more broadly? There are a number of significant differences.

Recall that the burden of these diseases falls disproportionately on those suffering greatest poverty. One reason for this is the familiar challenge of public policy, that measures intended to improve the position of those in most need tend to benefit most those who need it least (Mitton et al., 2009). Whilst aggregate standards of health may improve, health inequality in the community continues to widen (House of Commons, 2008-09). Bear in mind too that from 2010, the Conservative-led government's policy of public welfare austerity most significantly affected the most deprived members of the community (Ray-Chaudhuri et al., 2024). Thus, the public health budgets of those areas most in need have been diminishing precisely as public authorities have the potential to contribute most to the public health debate (Marmot, 2020).

If ethical frameworks are helpful for fairness, consistency and transparency, how should public health priorities committees approach the role of advising health authorities in relation to their health inequality duties? Crucially, this responsibility is concerned less with patients, and more with the needs of 'people' and the community in general. The tools at the disposal of directors of public health to respond to these needs are less about treatment, and more about creating preventative environments conducive to health, sometimes referred to as the 'upstream' determinants of health. Inevitably, from finite health authority budgets, decisions to commit resources to promote public health involve opportunity costs which impact on the resources available to (say) acute care in hospital or the notional drugs budget available to GPs in primary care. In the competition for scarce resources, which commands greater priority; the need to restore the workforce lost to the NHS (estimated at 115,000 clinical staff vacancies) (Care Quality Commission, 2021), the urgent repairs required to the NHS estate (NHS Confederation (b), 2023), or improved social care of babies at home and undernourished children in school?

The tension is sensitive because investment in public health takes longer to yield results. Inevitably, we must balance the delayed benefit of longer-term investment with the immediate and pressing need to reduce waiting times today.

Unlike priority setting for medical technologies (e.g. drugs and devices), these responses do not necessarily belong to a single health authority. Instead, they engage a range of public authority departments, including community care, education and housing and, indeed, central government itself. ~~What measures are available?~~Various measures are available. In England, for example, we have a Soft Drinks Industry Levy, smoking in public spaces has been banned and graphic images of disease on cigarette packaging are now required. Scotland and Wales impose minimum pricing on units of alcohol. Powerful arguments are made to regulate ultra processed food (House of Lords, 2024-25); so too. ~~? What about the~~~~Address~~ the fluoridation of water supplies and improving improve air quality.~~?~~ And locally, how should ICS' compare policies to (say) improve children's diets, the mental health of rough sleepers, or preventing falls at home? On what metric should these decisions be explained and differentiated?

Add to these challenges another significant difference, i.e. that the priority setting familiar to the NHS is neutral, procedural and reactive. Ethical frameworks for health technologies simply respond to the requests brought before them. By contrast, policies of the sort discussed above are political, substantive and proactive. The ambition of reducing inequality is political in the sense that it is concerned to redistribute rights, duties and power within the state (Coggon, 2012). It is inevitably contentious and proactive in the sense that it seeks to initiate measures to improve the position of particular groups of people by comparison to others. Clearly, 'politics' lies at the heart of many of these decisions concerning concepts such as autonomy, liberty, equality and paternalism (Newdick, 2017; Eskin, 2002); and crucially, whether health is a primary responsibility of government or of individuals (Daniels et al., 2000; Coggon and Kamunge-Kpodo, 2022; López and Gadsden, 2017). Acknowledging these challenges, the process still needs a procedural framework to ensure fairness, equality and consistency in population health policymaking. Public authorities must be capable of demonstrating that decision making is robust by reference to the evidence considered, how it is weighed and balanced, and the reasonableness of its conclusions. Crucially, however, processes alone cannot measure and compare the potential benefits for particular social groups of substantive interventions across so many departments.

On what evidence, therefore, should decision-making as to the *substantive* issues be based and according to what criteria? These questions lack the relative certainties of procedural fairness. Recall that we started talking about health inequalities in 1979 with the Black Report on inequalities in health (Townsend and Davidson, 1982). Even in 2006, the European Charter on Counteracting Obesity stated that "[t]he obesity epidemic is reversible… Visible progress, especially relating to children and adolescents, should be achievable in most countries in the next 4–5 years and it should be possible to reverse the trend by 2015 at the latest." (WHO, 2006). Yet, today: "Despite the publication of 14 government strategies to tackle obesity between 1992 and 2020 containing 689 policies, no progress has been made" (Food Foundation, 2024). Does this serve to strengthen the need for a coherent, consistent ethical framework to promote public health priorities? Or, on the other hand, does it only show that a coherent framework of priorities between so many variables of contested significance is a fruitless search for the holy grail?

C. Justice, Intersectionality and 'Non-Ideal' Approaches

We have emphasised the value of procedural fairness inherent in the NHS Constitution and local ethical frameworks, i.e. to encourage fairness, consistency and transparency in resource allocation in a way that is largely non-contentious. But this is not true of the social and commercial determinants of health which involve substantive interventions about which disagreement is endemic. ~~How should we approach this more~~For some, a response to this divisive challenge~~? One response is by~~ is to engage with ‘ideal’ theories of distributive justice to guide our thinking. Ideal approaches in health focus on establishing guiding principles to achieve an archetype of health equality, starting for example, with designing a perfectly just healthcare system, both as to the institutions responsible and the principles that govern them. Equality in access to healthcare services for all then becomes a benchmark or standard for all decision making.

Rawls’ doctrine of liberal equality provides an ideal approach which has featured prominently in the framing of the ethics of resource allocation. His theory puts fairness at its core, suggesting societal rules be chosen by individuals unaware of their status and characteristics. This, he argues, would guarantee basic liberties for all, promoting equality, but also prioritising the least advantaged members of society (Rawls, 1971). His conception of justice certainly illuminates healthcare policy objectives and the moral case for more equal access to the NHS (Germain, 2019). His theory has been criticised, however, for focusing on idealised principles which fail to grapple with contemporary structures which cannot readily provide achievable policy objectives (Valentini, 2010). Here we consider the shortcomings of ‘ideal’ approaches for reducing health inequality in order to uncover an approach capable of developing more pragmatic, ‘non-ideal’ solutions to the challenge for ethical frameworks for priority setting in public health. This, we argue, benefits from using an intersectional lens to address health inequalities.

1. The Shortcomings of an ‘Ideal Approach’

‘Ideal’ responses to the complex question of health inequality seek to present a comprehensive and coherent framework of guidance. They present difficulty, however, because they distil general principles from a paradigm of justice which exists only under utopian circumstances.

Rawls' theory, for example, provides an abstract moral framework for theoretical beings (Coggon, 2012). To be realised, his 'ideal approach' necessitates distancing from complex social contexts and from the intricate network of individual circumstances (Coggon, 2012). This is because it aims principally to establish a framework to shape 'perfectly just' basic institutions for society, without addressing the causes of the shortcomings of existing ones (Sen, 2009). The strict and unachievable conditions it mandates highlight the weakness of its pragmatism. Removing particularities to reach such a level of abstraction does not help promote equality (Coggon, 2012). By their essence, these issues cannot be reduced to single traits or properly understood by isolating one or a constellation of factors (Hankivsky, 2012). Identity categories, the classifications that individuals use to define themselves (e.g. race, gender, class or sexuality) are not only fluid and deeply influenced by location, but also entirely socially constructed. Framing an idea of justice in isolation from these factors cannot be conducive to the promotion of social equality (Ghasemi et al, 2021).

Like Coggon, we argue that a normative framework for reducing health inequalities cannot be designed in abstraction, away from the lives people actually live (Coggon, 2012). Environments and social factors need to be accounted for, as well as the dynamics of human experience, to achieve an 'effective' ideal (Larson et al., 2016). This is more likely to address the complex of inequalities which arise from these intersecting contexts. Pristine images of ideally just institutions are less likely to serve that purpose (Stemplowska and Smith, 2012). Indeed, their failure to provide workable solutions may even obstruct progress and perpetuate the *status quo* for failing to recognise the structural inequalities arising from positions of privilege (Wolff, 2007) and, in doing so, failing to achieve an 'ideal' approach (Pateman and Mills, 2007).

As a normative theory, an 'ideal approach' is simply too distant from the complexities that give rise to inequalities, particularly in health (Coggon, 20212). As previously discussed, they stem from multiple, socio-economic environments and affect people in very different ways (Yong and Germain, 2022). If we are serious about tackling health inequality, we need to step away from ideal benchmarks and turn to a more practicable approaches that will allow for more agile frameworks to differentiate and chose appropriate options. To do so, the uniqueness of individual experiences needs to be accounted for, particularly in respect of marginalised groups with complex identities (Borras, 2020). What we need, therefore, is a conception of justice that can help draw comparison among various propositions to support policy makers needing to balance competing issues (Stemplowska and Smith, 2012). Justice should be considered on a comparative basis rather than a set benchmark according to which policy options are measured. It seems natural to suggest that procedures should also be developed to engage with communities most directly affected (Germain and Veronesi, 2024). Only then will the complexities of the human experience and environment be adequately considered, and this will assist the design of an ethical framework that asks how we can positively advance equality in health, rather than develop a perfectly just health care system (Sen, 2009).

2. Intersectionality and Health Inequalities

In addition to our caution against abstraction in framing unachievable ‘ideals’ to anchor an ethical framework for public health, we propose a more comprehensive perspective on inequality to encompass the complex ways in which social experience shapes health (Lapalme et al, 2019). The concept of intersectionality offers a helpful way of doing so. Many health inequalities have remained hidden because of an over simplified picture of our society and the use we make of disaggregated data on a single identity axis to design laws and policies (Yong and Germain, 2022). Social science research has contributed to these shortcomings by overlooking the upstream structures that play a crucial role in perpetuating inequalities (Lapalme et al., 2019). This oversight, inherently linked to the idea of ‘epistemic injustice,’ has constrained our understanding of inequalities and the reasons for their persistence (Dunn, 2012; Chung, 2021).

Crenshaw's theory of intersectionality (Crenshaw, 1989) offers a lens through which we can gain a more accurate understanding of society, allowing us to better account for the impact of the social and commercial determinants of health on individuals and communities. Intersectionality acknowledges the role of structural factors in creating and sustaining forms of disadvantage (Hankivsky et al., 2014). As a context-informed approach, it unpacks the complexities of social stratification. Social stratifiers - such as age, class, ability, gender, geography, migration status, race, religion, sex, socioeconomic status - are criteria used to divide society into hierarchical categories. These stratifiers do not exist in isolation from each other, rather they are embedded within broader social systems including law, media, policy, religious institutions, and governments. These social categories also interact with structures of power such as ableism, ageism, colonialism, imperialism, patriarchy, racism, and xenophobia. Together, these systems and structures sustain inequalities by limiting consideration of the broader social determinants of health (Shannon et al., 2022).

Intersectionality recognises these structural causes of inequalities and the social patterns that sustain them (Kapilashrami et al., 2015). It also provides an entry point to understand empirically the mechanisms and power structures that have allowed social inequalities to endure (Lapalme et al., 2019). Engaging this perspective, Crenshaw explains that individuals or groups with 'intersecting' identities (at the convergence of multiple axes) can experience unique forms of disadvantage (or privilege) in how they are treated, as a result of the way others (or institutions) perceive their complex identities (Crenshaw, 1989). Intersectionality highlights the compounding and unique effects that social identities have on individuals or groups. It does not adopt an additive approach to explain oppression (Hankivsky (a), 2012). Instead, it offers a framing to understand how social locations and structural forces interact and shape the 'marginalising' experiences of some groups or individuals (Hankivsky, 2009). As an analytical tool, it helps us consider health inequality differently and more seriously, defying the notion of essentialism. Essentialism views human traits as innate, fixed and universally shared within groups (Philips, 2011) and has, thus far, led us to wrongly consider social groups as homogeneous (Hankivsky and Cormier, 2009; Hankivsky (b), 2012). By contrast, through an intersectional lens, social groups' multidimensionality becomes the focus. Attention is paid to social dynamics rather than fixed identity categories which help us better understand the complexity of health inequalities (Kapulashrami et al., 2015).

An intersectional perspective to the design of an ethical framework for priority setting offers the most promising approach to the challenge of health inequality (Borras, 2020). With this as a guide (Sen et al., 2009), we will be more likely to identify the health vulnerabilities that have been camouflaged by 'intersectional invisibility' (Bastos et al., 2018).

3. Intersectionality and 'Non-Ideal' Approaches

Social science research has broadened our theoretical understanding of the inequalities resulting from intersecting, social and commercial determinants of health by explaining how and why structural forces have created and reinforced them (Lapalme et al., 2019). The challenge is now to move from research into policy to develop a framework for guiding public health decision-making. The ambition of an intersectional lens needs to be translated into an actionable framework to guide the development of practicable responses to priority setting in public health.

So far, the implementation of intersectional frameworks (Hankivsky (a), 2012) has not gathered significant policy traction, perhaps because of the challenges of giving it practical implementation, including of everyday politics (Ghasemi et al., 2021). Intersectionality's focus on the uniqueness of lived experiences can make developing population level frameworks and policies difficult (Holman et al., 2021). It seeks to bridge the gaps between the theoretical utopia of 'ideal approaches' and the political reality of health inequalities (Stemplowska and Smith, 2012). Ideal approaches cannot achieve this objective (Stemplowska and Smith, 2012); indeed, they may be counterproductive, distracting us from solutions to health inequality (Sen, 2009). Instead, as Powers and Faden suggest,

> … the questions of what inequalities matter most and of what constellations of determinants are most important, cannot be answered in abstraction. Empirical inquiry is required to identify both how well people are doing and what elements of the social structure are having the most profound effects on the different aspects of well-being (Powers and Faden, 2006).

In other words, to improve health outcomes, we do not need to know which theories of distributive ethics are the best. Instead, we need to understand which interventions are available in our communities and how they compare in terms of impact and feasibility. This focuses more clearly on realising justice through feasible and practicable social arrangements (Gledhill, 2014). So too, for the procedural components of decision-making, ie those who decide, their expertise and the public authorities involved. While not theoretically perfect, this 'non-ideal' path is better suited to respond to the realities that have constrained the achievement of health justice for many marginalised groups (Sayegh, 2017). Even without a completely formed 'ideal' it can help to define targets and outline a path for action (Sreenivasan, 2007). Crucially, the starting point is not theoretical, but an assessment of the range of currently available policy options, opportunities and their limitations.

D. Implementing an Ethical Framework for Health Inequality

Non-ideal solutions offer the most promising mechanism for responding to the challenge of health inequality while taking an intersectional perspective that accounts for structural forms of disadvantage.

Explaining the potential for doing so, we consider existing statutory structures to emphasise the duties on NHS bodies and local authority departments to work together. ICBs must integrate their services with other health-related and social care services to tackle health inequalities.[5] The 2022 reforms enhance the advisory role of local authorities and Health and Wellbeing Boards. For example, ICBs must obtain appropriate advice, including from Directors of Public Health.[6] They must 'co-operate' with local authorities,[7] publish strategies describing how their services could be integrated and consult local Health and Wellbeing Boards in preparing annual plans.[8] NHS and local authority bodies may pool their budgets to improve services,[9] (Knowsley Council, 2014; Bristol One City Approach), Health and Wellbeing Boards may 'express an opinion' to NHS England (and, after its abolition, the Department of Health and Social Care) whether its ICB has properly considered the local health and wellbeing strategy[10] and Overview and Scrutiny Committees, with persuasive powers to 'champion' population health (Campbell, 2010), maintain watchful eyes over the process (Local Authority, 2002; Local Authority 2013; DHSC (b), 2024).

Yet, despite the clarity of the ambition, uncertainty surrounds the practical working of this structure. Shortly after taking office, the incoming 2024 Labour government appointed Lord Darzi to investigate and report on the state of the NHS after a decade of austerity funding. In respect of these statutory duties, the investigation found that some ICBs pursue a positive role by tackling the social and commercial determinants of health. Others confine their public health duties to the supply of healthcare. But some do neither, concentrating their focus simply on the performance management of hospitals (DHSC (a), 2024). The new integrated care system (ICS) intends, amongst other things, to "tackle inequalities in outcomes, experience and access" (NHS England, 2023), but what is so plainly absent is a framework of principles and priorities to achieve this objective. As Patricia Hewitt, a previous Secretary of State for Health, said in her report to the Conservative Sunak government: "We have created ICSs but not yet the context in which they can thrive and deliver" (Hewitt, 2023). On the one hand, around "80% of health outcomes are determined by non-health related inputs, such as education, employment, housing and the environment" (Health and Social Care Committee, 2022-23) because they arise 'upstream' from the NHS, within local authority responsibility. On the other, the dominant party within the integrated care system remains ICBs chiefly responsible for organising health care. As we have seen, local authorities must be consulted and have an enhanced advisory role, but ICBs retain ultimate decision-making authority. Inescapably, however, ICB capacity to "think creatively about longer-term solutions is likely to be highly limited..." (King's Fund, 2022-23).

Add to this that the 'public health grant' to local authorities, valued at around £3.5bn in 2023/24 (DHSC (a), 2023), has consistently declined over the past 10 years and is now 10% less than in 2013/14 in real terms (King's Fund, 2023). So, precisely when the statutory levers to tackle health inequalities convey most potential for integration, there is uncertainty as to their practical impact and mounting constraint on the capacity to respond. ICSs urgently need a framework to support partnerships (eg, between ICBs, ICPs, HWBs, local authorities, voluntary and charitable organisations), including examples where co-operation is likely to help.[11]

There is an argument for significant central leadership, for example, from HM Treasury to identify priorities and drive targets though the establishment of a new *Prevention Investment Unit*, with statutory powers under a new Public Investment Act, (Demos and the Health Foundation, 2025). However, in the absence of a model supplied centrally, the issue remains within the discretion of ICBs, together with their local authority partners~~how should we~~

~~proceed?~~.[12] What is required is a generic approach with broad-based support around which ICSs can congregate. One such 'non-ideal' framework, sufficiently flexible to accommodate an intersectional approach, is offered by the Marmot Review of 2010. Sir Michael Marmot is Professor of Epidemiology at University College London and leads the Institute for Health Equity. Through his health inequalities work for, *inter alia,* the World Health Organization and the British government, Sir Michael has created an authoritative framework of recommendations to reduce health inequality, starting with a focus on children.[13] In 2010, he identified the following six policy domains, i.e.:

(1) Give every child the best start in life,[14]

(2) Enable all children, young people and adults to maximise their capabilities and have control over their lives,

(3) Create fair employment and good work for all,

(4) Ensure healthy standards of living for all,

(5) Create and develop healthy and sustainable places and communities,

(6) Strengthen the role and impact of ill health prevention. (Marmot, 2010)

To this, two further areas were added in 2020 in the context of the SARS-CoV2 public health crisis:

(7) Tackle racism, discrimination and their outcomes,

(8) Pursue environmental sustainability and health equity together. (Marmot, 2020)

Each domain encourages a holistic perspective and provides an opportunity to take an intersectional approach to craft adapted solutions to more effectively account for complex experiences of health inequality. Now we need to develop the partnership arrangements required to support these objectives. These priorities have inspired over 40 local authorities across the UK to become 'Marmot Places,' which address health inequality by proactively engaging in programmes that embody the eight key areas. Practice varies as ICS' respond to local circumstances. Each 'Marmot Place' plans interventions for its local population to foster sustainable systemic change in the long term, though no external financial support is provided for them to do so (Dean, 2024). 'Marmot Places' and 'Marmot Cities'[15] and at a smaller scale, 'Marmot Boroughs' receive guidance from The Institute for Health Equity. The Institute supports local authorities to assess the extent of inequalities in their area and identify valuable existing initiatives and gaps in their programmes, to generate a plan for collaboration with local bodies (Dean, 2024). Although recommendations vary in scale and scope, the focus is always on initiatives that go beyond the delivery of healthcare services to address the root causes of inequalities. Acknowledging that the NHS alone cannot tackle the complex issues affecting population health, the 'Marmot Eight' principles set out to "develop and deliver interventions and policies to improve health equity; embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity" (Institute of Health Equity, 2024).

The 'Marmot approach' focuses on lived experiences to set priorities and build strong accountability locally and at the higher official echelons (Dean, 2024). Whether by interventions which target environmental, socioeconomic or behavioural factors, or access to health care and outcomes, the foundation for action is not an abstract theory of distributive justice. Rather, priority is placed on responding to the inequalities suffered by the most deprived and marginalised parts of the community based on the principles of proportionate universalism which seeks to make the scale and intensity of action proportionate to the level of disadvantage (Albini, 2024). For example, Coventry, a 'Marmot City' since 2013, has adopted policies that focus on reducing digital exclusion, making remote services more accessible, optimising transport for in person services, increasing pre-employment apprenticeships and work placements, and improving mental health, to specifically support young populations in its most deprived areas (Coventry City Council, 2024). Coventry's local authorities want all residents, including its most vulnerable, to have the opportunity to benefit from 'good growth', something they believe will generate jobs, better housing and other benefits to the city (Coventry City Council, 2024).

'Marmot Places' are good examples of pragmatic, non-ideal solutions at a local level. They offer a helpful framework to guide priority-setting to reduce health inequality. All Marmot areas seek to better integrate interventions to tackle health inequality by coordinating the work of local government, the NHS, the voluntary and community sectors, other public services (eg, education, criminal justice and transport), and the business and private sector. They have the advantage of a flexible starting point about which there is widespread support and from which information about successes and failures can evolve.

CONCLUSION

ICBs have clear statutory duties as to health inequalities, so they must do something; the question is what? We have described how the NHS Constitution has promoted the notion of procedural fairness in priority setting. However, this is very different from the substantive duty to reduce health inequality. Certainly, the NHS and local authorities have a procedural duty to co-operate and integrate their services, but its potential for tackling health inequality is uncertain. In the absence of a national framework for action or coherent theoretical response, we endorse a pragmatic approach to the challenge of health inequality, grounded in the reality of the lives people actually lead. The 'Marmot Eight' principles offer a constructive response, at least for the present, not because they are 'ideal', nor because they are the only possible options. They are, however, manifestly plausible responses about which health authorities could unite and collaborate by sharing experience and learning.

Equally, we should acknowledge that corporate and mass media interests are always likely to resist change, arguing perhaps that interfering with individual lifestyle is an unwarranted, "nanny state" infringement of liberty by "food fascists" (Marmot, 2013; Le Grand and New, 2015)? For example, "climate change, obesity, drinking, smoking, gambling, and abuse of pharmaceutical opioids are overwhelmingly framed as poor individual choices: the problem gambler; irresponsible drinker…" (Gilmore et al., 2023; Paetkau, 2024). This may equally serve to deflect attention from governments' own failures to invest in population health (Deaton, 2013; WHO, 2024; Joseph, 2013; Chadwick, 2019). We have considered the position in England. In truth, however, the roots of deepening inequality are more widespread and lie in the power and influence arising from global structures that concentrate private capital and political influence in increasingly fewer hands (Picketty, 2020; Stiglitz, 2013; Newdick (b), 2016) and, correspondingly in the UK, the belief that austerity justifies faltering investment in public services relative to GDP (Ogden and Phillips, 2023). Short of a Polanyian transformation in the narrative about the value of public services to social solidarity (Polanyi, 1957; Wilkinson and Pickett, 2010; Mazzucato, 2018; Atkinson, 2015), productive policies to reduce health inequality will always face a steep uphill struggle.

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[1] Under the National Assistance Act 1948, Part III.

[2] On the meaning of the comparable duty of the Secretary of State to have "due regard" to the Public Sector Equality Duty in s 149(1) of the Equality Act 2010, see *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, [26] and at [61]: "advance consideration has to be given to these issues and they have to be an integral part of the mechanisms of government... There is a need for a conscious approach and the duty must be exercised in substance, with rigour and with an open mind…"

[3] *NHS Constitution* (DHSC, 2023), "You have the right to expect local decisions on funding of… drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you." This is given statutory force by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regs 2012, SI 2996, Part 7. Note, ICBs have replaced CCGs, see

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the National Health Service Act 2006 s 14Z25 *et seq* as amended by the Health and Care Act 2022 (Consequential and Related Amendments and Transitional Provisions) Regulations 2022, SI 634, reg 58.

[4] See for example, the Buckinghamshire, Oxfordshire and Berkshire ICB and Frimley ICB Ethical Framework, available here: https://fundingrequests.scwcsu.nhs.uk/thames-valley-priorities-committee/.

[5] National Health Service Act, 2006, s.14Z42 (as amended by the Health and Care Act 2022).

[6] National Health Service Act, 2006, 14Z38 (as amended by the 2022 Act).

[7] National Health Service Act, 2006, s.82s, (as amended by the 2022 Act).

[8] National Health Service Act, 2006, s.116Zb (4) and s14Z54(3) (as amended by the 2022 Act).

[9] National Health Service Act, 2006 s.75, s.65Z and s.75 (as amended by the 2022 Act)

[10] National Health Service Act, 2006, s.14Z55 (as amended by the 2022 Act).

[11] The DHSC has yet to fulfil its promise: "To support investment in prevention, NHS England and DHSC will work closely with ICSs, local government partners and NICE to develop practical information and evidence to support local investment decisions." (DHSC, (b) 2023).

[12] Note, we have yet to develop reliable ways of quantifying and comparing non-clinical, cross-departmental policies to reduce health inequality (unlike QALYs for health care *technology*), although NICE has published a repository of related guidelines concerning health inequality (NICE, 2022). See also Malcolm et al., 2023.

[13] For the first time since the creation of the NHS, it is reported that the average height of children is in decline in the UK, whilst the numbers suffering obesity and type 2 diabetes is increasing (Food Foundation, 2024).

[14] On the Sure Start programme, "…the programme was inequality-reducing from early childhood all the way through adolescence… driven by a significant increase in lifetime earnings from improved academic performance at age 16… If we were to consider the reduction in hospitalisations… children's social care provision and juvenile offending, the cost–benefit figures might improve even further" (Carneiro et al., 2024 at 43).

[15] In 2013, Coventry became the first "Marmot City" basing its planning on the findings of the Marmot Review (2010) to boost the health of its residents particularly those living in deprived areas of the city and young people.

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PRIORITY SETTING FOR HEALTH EQUALITY – SEARCHING FOR AN ETHICAL FRAMEWORK

Abstract:

Compounded by 14 years of public welfare austerity, health equality presents a challenge that extends beyond healthcare in isolation because it also engages the more recondite politics of public health. Recent policy has addressed the issue by requiring NHS bodies to integrate their services with those of local authorities. We consider how this adds significant new difficulty to the already complex process of NHS resource allocation. We argue that these duties require a new framework to gauge the values, evidence and criteria needed to set priorities for public health; not simply as a desirable objective, but a necessity in law. We consider current approaches to priority setting for medical treatment, and the responses already offered by current ethical frameworks. We then discuss the new ethical, political, and practical challenges posed by public health priority setting for health equality. Informed by this context, we engage an intersectional lens to explore a 'non-ideal' solution grounded in Professor Sir Michael Marmot's framework to reduce health inequalities.

Introduction

NHS resource allocation has never been easy, but it is becoming increasingly challenging. One immediate difficulty concerns managing competing priorities for treatment following "the most austere decade since the NHS was founded…" (DHSC, 2024 (a); See also, Hernandez, 2021; NHS Confederation (a), 2023; Harker, 2019; Stoye et al., 2024). Still more difficult, however, are the new statutory duties in England about reducing health inequality. This is the issue we address here.

Health inequality reflects economic inequalities, particularly, poverty (Institute for Fiscal Studies, 2024). The chronic diseases treated by the NHS do not simply rise from patients struck at random. Instead, they are often predicted by the social and commercial determinants of health (Mindell et al., 2014; Schrecker and Bambra, 2015). "Poor health is strongly associated with living in socioeconomically deprived areas. A girl born today in the most deprived 10% of local areas is expected to live 20 fewer years in good health than a girl born in the least deprived." (Finch et al., 2024). Previously, concerns about inequality were not the primary responsibility of the NHS. For example, the inequalities of underprivileged children, poor housing and homelessness fell to local authorities.[1] Today that has changed. Since 2012, NHS bodies in England have had a duty, restated by the Health and Care Act 2022, to "have regard to the need to reduce health inequalities between persons" as to both their ability to access care and the outcomes achieved for them,[2] by integrating their services with those of local authorities.

Given the immensity of the challenge, we urgently need a framework to determine how to perform these new duties. As Dorling has said: "The UK is now very likely to be the most economically unequal country in Europe… the most expensive and poorest-quality housing, the most precarious and often lowest-paying work for so many people, the lowest state pension and the stingiest welfare benefits [and] the sharpest declines in health… especially of its children" (Dorling, 2023). Ideally, therefore, appropriate public health responses should be identified within a clear framework of ethical values, determined by appropriate stakeholders and guided by robust evidence and well-defined criteria. However, the practical implementation of such an approach presents a challenge. Within what set of ethical values should such a framework be constructed, by whom, and subject to what evidence and criteria? For example, we may disagree whether to assign priorities to the effects of the physical environment (such as the dangers arising from air and water quality, sanitation, and poor housing); the social and economic determinants of health, (e.g. education, housing, employment, race, gender and welfare support); ready access to healthcare; or to unhealthy behaviours (such as diet and exercise, and the use tobacco, alcohol and drugs). How should factors like these be prioritised, measured and compared?

We consider: (A) the current approaches to NHS priority setting for medical treatments in England and explain the helpful response of ethical frameworks. We then discuss more broadly (B) the significant new ethical, political and practical challenges posed by public health priority-setting to address health inequality. (C) We highlight the advantages of an intersectional perspective to assist the formulation of an ethical approach which addresses the root causes of health inequalities. Finally, in the absence of workable guidance from the centre, we discuss (D) a 'non-ideal' solution, grounded in Professor Sir Michael Marmot's pragmatic approach to tackling health inequality in England.

A. NHS Priority Setting for Treatments – Current Approaches

Priority setting is familiar to NHS health authorities. In respect of medicines, local recommendations to commission NHS treatments still fall to health authorities (currently integrated care boards (ICBs)). Priority setting requires health authorities to comply with the NHS Constitution and, therefore, to explain their decision-making.[3] Many appoint 'priorities committees' or 'medicines optimisation committees' to assist them, guided by ethical frameworks of principles to take decisions and explain their reasons. For example, in common with many others, the South East Region health authorities engage an Ethical Framework which sets down a small number of general statements to guide decision-making, referring to principles such as equality, costs of treatment and opportunity costs, quality of clinical evidence and exceptional need.[4] Requests for funding for new treatments may be submitted by doctors, pharmacists, hospitals and health authorities based on their experiences of need within the local NHS. New treatment applications are assessed by reference to an ethical framework as a way of promoting fairness, consistency and transparency in decision-making (Newdick (a), 2016; Newdick, 2014).

Priorities committees offer advice only to ICBs and may also recommend not to commission a treatment, for example, because it is unaffordable within the local NHS or the evidence of efficacy is unpersuasive. Health authorities may, therefore, decide not to support the treatment except in cases of exceptional need. Of course, this is not an exact science and disagreements can arise between decision-makers. Nevertheless, certain components of the process are reasonably well-understood. Aside from these ethical principles, the focus is on the benefit to be gained from the 'treatment' of 'patients' by use of 'healthcare' having regard to the best clinical trials evidence and the impact of the costs of purchase on a finite budget (including reference to QALYs). These ethical frameworks are an impartial starting point, a neutral explanatory tool against which applications are tested and assessed.

Decision-making tools of this nature are not simply desirable. They are essential to enable health authorities to demonstrate qualities vital in the law of judicial review, especially that policymaking is rational and proportionate. Frameworks of this nature assist fairness and consistency in decision-making. As a process for responding to patients (and judicial review), these frameworks have been reasonably effective. Crucially, however, they have not created substantive rights for patients, i.e. rights of access to particular care and treatment. They do no more than establish a model of procedural rights which seek to guarantee the ideal of a fair, equal and consistent process for decision-making, often referred to as "accountability for reasonableness" (Daniels, 2008).

B. Health Inequality Priority Setting – the New Challenge

If this process has been helpful in relation to the allocation of resources for medicines to treat patients after they have fallen ill, to what extent is it relevant to measures concerned to reduce health inequalities more broadly? There are a number of significant differences.

Recall that the burden of these diseases falls disproportionately on those suffering greatest poverty. One reason for this is the familiar challenge of public policy, that measures intended to improve the position of those in most need tend to benefit most those who need it least (Mitton et al., 2009). Whilst aggregate standards of health may improve, health inequality in the community continues to widen (House of Commons, 2008-09). Bear in mind too that from 2010, the Conservative-led government's policy of public welfare austerity most significantly affected the most deprived members of the community (Ray-Chaudhuri et al., 2024). Thus, the public health budgets of those areas most in need have been diminishing precisely as public authorities have the potential to contribute most to the public health debate (Marmot, 2020).

If ethical frameworks are helpful for fairness, consistency and transparency, how should public health priorities committees approach the role of advising health authorities in relation to their health inequality duties? Crucially, this responsibility is concerned less with patients, and more with the needs of 'people' and the community in general. The tools at the disposal of directors of public health to respond to these needs are less about treatment, and more about creating preventative environments conducive to health, sometimes referred to as the 'upstream' determinants of health. Inevitably, from finite health authority budgets, decisions to commit resources to promote public health involve opportunity costs which impact on the resources available to (say) acute care in hospital or the notional drugs budget available to GPs in primary care. In the competition for scarce resources, which commands greater priority; the need to restore the workforce lost to the NHS (estimated at 115,000 clinical staff vacancies) (Care Quality Commission, 2021), the urgent repairs required to the NHS estate (NHS Confederation (b), 2023), or improved social care of babies at home and undernourished children in school?

The tension is sensitive because investment in public health takes longer to yield results. Inevitably, we must balance the delayed benefit of longer-term investment with the immediate and pressing need to reduce waiting times today.

Unlike priority setting for medical technologies (e.g. drugs and devices), these responses do not necessarily belong to a single health authority. Instead, they engage a range of public authority departments, including community care, education and housing and, indeed, central government itself. Various measures are available. In England, for example, we have a Soft Drinks Industry Levy, smoking in public spaces has been banned and graphic images of disease on cigarette packaging are now required. Scotland and Wales impose minimum pricing on units of alcohol. Powerful arguments are made to regulate ultra processed food (House of Lords, 2024-25); so too the fluoridation of water supplies and improving improve air quality. And locally, how should ICS' compare policies to (say) improve children's diets, the mental health of rough sleepers, or preventing falls at home? On what metric should these decisions be explained and differentiated?

Add to these challenges another significant difference, i.e. that the priority setting familiar to the NHS is neutral, procedural and reactive. Ethical frameworks for health technologies simply respond to the requests brought before them. By contrast, policies of the sort discussed above are political, substantive and proactive. The ambition of reducing inequality is political in the sense that it is concerned to redistribute rights, duties and power within the state (Coggon, 2012). It is inevitably contentious and proactive in the sense that it seeks to initiate measures to improve the position of particular groups of people by comparison to others. Clearly, 'politics' lies at the heart of many of these decisions concerning concepts such as autonomy, liberty, equality and paternalism (Newdick, 2017; Eskin, 2002); and crucially, whether health is a primary responsibility of government or of individuals (Daniels et al., 2000; Coggon and Kamunge-Kpodo, 2022; López and Gadsden, 2017). Acknowledging these challenges, the process still needs a procedural framework to ensure fairness, equality and consistency in population health policymaking. Public authorities must be capable of demonstrating that decision making is robust by reference to the evidence considered, how it is weighed and balanced, and the reasonableness of its conclusions. Crucially, however, processes alone cannot measure and compare the potential benefits for particular social groups of substantive interventions across so many departments.

On what evidence, therefore, should decision-making as to the *substantive* issues be based and according to what criteria? These questions lack the relative certainties of procedural fairness. Recall that we started talking about health inequalities in 1979 with the Black Report on inequalities in health (Townsend and Davidson, 1982). Even in 2006, the European Charter on Counteracting Obesity stated that "[t]he obesity epidemic is reversible… Visible progress, especially relating to children and adolescents, should be achievable in most countries in the next 4–5 years and it should be possible to reverse the trend by 2015 at the latest." (WHO, 2006). Yet, today: "Despite the publication of 14 government strategies to tackle obesity between 1992 and 2020 containing 689 policies, no progress has been made" (Food Foundation, 2024). Does this serve to strengthen the need for a coherent, consistent ethical framework to promote public health priorities? Or, on the other hand, does it only show that a coherent framework of priorities between so many variables of contested significance is a fruitless search for the holy grail?

C. Justice, Intersectionality and 'Non-Ideal' Approaches

We have emphasised the value of procedural fairness inherent in the NHS Constitution and local ethical frameworks, i.e. to encourage fairness, consistency and transparency in resource allocation in a way that is largely non-contentious. But this is not true of the social and commercial determinants of health which involve substantive interventions about which disagreement is endemic. For some, a response to this divisive challenge is to engage with 'ideal' theories of distributive justice to guide our thinking. Ideal approaches in health focus on establishing guiding principles to achieve an archetype of health equality, starting for example, with designing a perfectly just healthcare system, both as to the institutions responsible and the principles that govern them. Equality in access to healthcare services for all then becomes a benchmark or standard for all decision making.

Rawls' doctrine of liberal equality provides an ideal approach which has featured prominently in the framing of the ethics of resource allocation. His theory puts fairness at its core, suggesting societal rules be chosen by individuals unaware of their status and characteristics. This, he argues, would guarantee basic liberties for all, promoting equality, but also prioritising the least advantaged members of society (Rawls, 1971). His conception of justice certainly illuminates healthcare policy objectives and the moral case for more equal access to the NHS (Germain, 2019). His theory has been criticised, however, for focusing on idealised principles which fail to grapple with contemporary structures which cannot readily provide achievable policy objectives (Valentini, 2010). Here we consider the shortcomings of 'ideal' approaches for reducing health inequality in order to uncover an approach capable of developing more pragmatic, 'non-ideal' solutions to the challenge for ethical frameworks for priority setting in public health. This, we argue, benefits from using an intersectional lens to address health inequalities.

1. The Shortcomings of an 'Ideal Approach'

'Ideal' responses to the complex question of health inequality seek to present a comprehensive and coherent framework of guidance. They present difficulty, however, because they distil general principles from a paradigm of justice which exists only under utopian circumstances. Rawls' theory, for example, provides an abstract moral framework for theoretical beings

(Coggon, 2012). To be realised, his 'ideal approach' necessitates distancing from complex social contexts and from the intricate network of individual circumstances (Coggon, 2012). This is because it aims principally to establish a framework to shape 'perfectly just' basic institutions for society, without addressing the causes of the shortcomings of existing ones (Sen, 2009). The strict and unachievable conditions it mandates highlight the weakness of its pragmatism. Removing particularities to reach such a level of abstraction does not help promote equality (Coggon, 2012). By their essence, these issues cannot be reduced to single traits or properly understood by isolating one or a constellation of factors (Hankivsky, 2012). Identity categories, the classifications that individuals use to define themselves (e.g. race, gender, class or sexuality) are not only fluid and deeply influenced by location, but also entirely socially constructed. Framing an idea of justice in isolation from these factors cannot be conducive to the promotion of social equality (Ghasemi et al, 2021).

Like Coggon, we argue that a normative framework for reducing health inequalities cannot be designed in abstraction, away from the lives people actually live (Coggon, 2012). Environments and social factors need to be accounted for, as well as the dynamics of human experience, to achieve an 'effective' ideal (Larson et al., 2016). This is more likely to address the complex of inequalities which arise from these intersecting contexts. Pristine images of ideally just institutions are less likely to serve that purpose (Stemplowska and Smith, 2012). Indeed, their failure to provide workable solutions may even obstruct progress and perpetuate the *status quo* for failing to recognise the structural inequalities arising from positions of privilege (Wolff, 2007) and, in doing so, failing to achieve an 'ideal' approach (Pateman and Mills, 2007).

As a normative theory, an 'ideal approach' is simply too distant from the complexities that give rise to inequalities, particularly in health (Coggon, 20212). As previously discussed, they stem from multiple, socio-economic environments and affect people in very different ways (Yong and Germain, 2022). If we are serious about tackling health inequality, we need to step away from ideal benchmarks and turn to a more practicable approaches that will allow for more agile frameworks to differentiate and chose appropriate options. To do so, the uniqueness of individual experiences needs to be accounted for, particularly in respect of marginalised groups with complex identities (Borras, 2020). What we need, therefore, is a conception of justice that can help draw comparison among various propositions to support policy makers needing to balance competing issues (Stemplowska and Smith, 2012). Justice should be considered on a comparative basis rather than a set benchmark according to which policy options are measured. It seems natural to suggest that procedures should also be developed to engage with communities most directly affected (Germain and Veronesi, 2024). Only then will the complexities of the human experience and environment be adequately considered, and this will assist the design of an ethical framework that asks how we can positively advance equality in health, rather than develop a perfectly just healthcare system (Sen, 2009).

2. Intersectionality and Health Inequalities

In addition to our caution against abstraction in framing unachievable ‘ideals’ to anchor an ethical framework for public health, we propose a more comprehensive perspective on inequality to encompass the complex ways in which social experience shapes health (Lapalme et al, 2019). The concept of intersectionality offers a helpful way of doing so. Many health inequalities have remained hidden because of an over simplified picture of our society and the use we make of disaggregated data on a single identity axis to design laws and policies (Yong and Germain, 2022). Social science research has contributed to these shortcomings by overlooking the upstream structures that play a crucial role in perpetuating inequalities (Lapalme et al., 2019). This oversight, inherently linked to the idea of ‘epistemic injustice,’ has constrained our understanding of inequalities and the reasons for their persistence (Dunn, 2012; Chung, 2021).

Crenshaw's theory of intersectionality (Crenshaw, 1989) offers a lens through which we can gain a more accurate understanding of society, allowing us to better account for the impact of the social and commercial determinants of health on individuals and communities. Intersectionality acknowledges the role of structural factors in creating and sustaining forms of disadvantage (Hankivsky et al., 2014). As a context-informed approach, it unpacks the complexities of social stratification. Social stratifiers - such as age, class, ability, gender, geography, migration status, race, religion, sex, socioeconomic status - are criteria used to divide society into hierarchical categories. These stratifiers do not exist in isolation from each other, rather they are embedded within broader social systems including law, media, policy, religious institutions, and governments. These social categories also interact with structures of power such as ableism, ageism, colonialism, imperialism, patriarchy, racism, and xenophobia. Together, these systems and structures sustain inequalities by limiting consideration of the broader social determinants of health (Shannon et al., 2022).

Intersectionality recognises these structural causes of inequalities and the social patterns that sustain them (Kapilashrami et al., 2015). It also provides an entry point to understand empirically the mechanisms and power structures that have allowed social inequalities to endure (Lapalme et al., 2019). Engaging this perspective, Crenshaw explains that individuals or groups with 'intersecting' identities (at the convergence of multiple axes) can experience unique forms of disadvantage (or privilege) in how they are treated, as a result of the way others (or institutions) perceive their complex identities (Crenshaw, 1989). Intersectionality highlights the compounding and unique effects that social identities have on individuals or groups. It does not adopt an additive approach to explain oppression (Hankivsky (a), 2012). Instead, it offers a framing to understand how social locations and structural forces interact and shape the 'marginalising' experiences of some groups or individuals (Hankivsky, 2009). As an analytical tool, it helps us consider health inequality differently and more seriously, defying the notion of essentialism. Essentialism views human traits as innate, fixed and universally shared within groups (Philips, 2011) and has, thus far, led us to wrongly consider social groups as homogeneous (Hankivsky and Cormier, 2009; Hankivsky (b), 2012). By contrast, through an intersectional lens, social groups' multidimensionality becomes the focus. Attention is paid to social dynamics rather than fixed identity categories which help us better understand the complexity of health inequalities (Kapulashrami et al., 2015).

An intersectional perspective to the design of an ethical framework for priority setting offers the most promising approach to the challenge of health inequality (Borras, 2020). With this as a guide (Sen et al., 2009), we will be more likely to identify the health vulnerabilities that have been camouflaged by 'intersectional invisibility' (Bastos et al., 2018).

3. Intersectionality and 'Non-Ideal' Approaches

Social science research has broadened our theoretical understanding of the inequalities resulting from intersecting, social and commercial determinants of health by explaining how and why structural forces have created and reinforced them (Lapalme et al., 2019). The challenge is now to move from research into policy to develop a framework for guiding public health decision-making. The ambition of an intersectional lens needs to be translated into an actionable framework to guide the development of practicable responses to priority setting in public health.

So far, the implementation of intersectional frameworks (Hankivsky (a), 2012) has not gathered significant policy traction, perhaps because of the challenges of giving it practical implementation, including of everyday politics (Ghasemi et al., 2021). Intersectionality's focus on the uniqueness of lived experiences can make developing population level frameworks and policies difficult (Holman et al., 2021). It seeks to bridge the gaps between the theoretical utopia of ‘ideal approaches’ and the political reality of health inequalities (Stemplowska and Smith, 2012). Ideal approaches cannot achieve this objective (Stemplowska and Smith, 2012); indeed, they may be counterproductive, distracting us from solutions to health inequality (Sen, 2009). Instead, as Powers and Faden suggest,

> … the questions of what inequalities matter most and of what constellations of determinants are most important, cannot be answered in abstraction. Empirical inquiry is required to identify both how well people are doing and what elements of the social structure are having the most profound effects on the different aspects of well-being (Powers and Faden, 2006).

In other words, to improve health outcomes, we do not need to know which theories of distributive ethics are the best. Instead, we need to understand which interventions are available in our communities and how they compare in terms of impact and feasibility. This focuses more clearly on realising justice through feasible and practicable social arrangements (Gledhill, 2014). So too, for the procedural components of decision-making, i.e. those who decide, their expertise and the public authorities involved. While not theoretically perfect, this ‘non-ideal’ path is better suited to respond to the realities that have constrained the achievement of health justice for many marginalised groups (Sayegh, 2017). Even without a completely formed ‘ideal’ it can help to define targets and outline a path for action (Sreenivasan, 2007). Crucially, the starting point is not theoretical, but an assessment of the range of currently available policy options, opportunities and their limitations.

D. Implementing an Ethical Framework for Health Inequality

Non-ideal solutions offer the most promising mechanism for responding to the challenge of health inequality while taking an intersectional perspective that accounts for structural forms of disadvantage.

Explaining the potential for doing so, we consider existing statutory structures to emphasise the duties on NHS bodies and local authority departments to work together. ICBs must integrate their services with other health-related and social care services to tackle health inequalities.[5] The 2022 reforms enhance the advisory role of local authorities and Health and Wellbeing Boards. For example, ICBs must obtain appropriate advice, including from Directors of Public Health.[6] They must 'co-operate' with local authorities,[7] publish strategies describing how their services could be integrated and consult local Health and Wellbeing Boards in preparing annual plans.[8] NHS and local authority bodies may pool their budgets to improve services,[9] (Knowsley Council, 2014; Bristol One City Approach), Health and Wellbeing Boards may 'express an opinion' to NHS England (and, after its abolition, the Department of Health and Social Care) whether its ICB has properly considered the local health and wellbeing strategy[10] and Overview and Scrutiny Committees, with persuasive powers to 'champion' population health (Campbell, 2010), maintain watchful eyes over the process (Local Authority, 2002; Local Authority 2013; DHSC (b), 2024).

Yet, despite the clarity of the ambition, uncertainty surrounds the practical working of this structure. Shortly after taking office, the incoming 2024 Labour government appointed Lord Darzi to investigate and report on the state of the NHS after a decade of austerity funding. In respect of these statutory duties, the investigation found that some ICBs pursue a positive role by tackling the social and commercial determinants of health. Others confine their public health duties to the supply of healthcare. But some do neither, concentrating their focus simply on the performance management of hospitals (DHSC (a), 2024). The new integrated care system (ICS) intends, amongst other things, to "tackle inequalities in outcomes, experience and access" (NHS England, 2023), but what is so plainly absent is a framework of principles and priorities to achieve this objective. As Patricia Hewitt, a previous Secretary of State for Health, said in her report to the Conservative Sunak government: "We have created ICSs but not yet the context in which they can thrive and deliver" (Hewitt, 2023). On the one hand, around "80% of health outcomes are determined by non-health related inputs, such as education, employment, housing and the environment" (Health and Social Care Committee, 2022-23) because they arise 'upstream' from the NHS, within local authority responsibility. On the other, the dominant party within the integrated care system remains ICBs chiefly responsible for organising health care. As we have seen, local authorities must be consulted and have an enhanced advisory role, but ICBs retain ultimate decision-making authority. Inescapably, however, ICB capacity to "think creatively about longer-term solutions is likely to be highly limited..." (King's Fund, 2022-23).

Add to this that the 'public health grant' to local authorities, valued at around £3.5bn in 2023/24 (DHSC (a), 2023), has consistently declined over the past 10 years and is now 10% less than in 2013/14 in real terms (King's Fund, 2023). So, precisely when the statutory levers to tackle health inequalities convey most potential for integration, there is uncertainty as to their practical impact and mounting constraint on the capacity to respond. ICSs urgently need a framework to support partnerships (e.g., between ICBs, ICPs, HWBs, local authorities, voluntary and charitable organisations), including examples where co-operation is likely to help.[11]

There is an argument for significant central leadership, for example, from HM Treasury to identify priorities and drive targets though the establishment of a new *Prevention Investment Unit*, with statutory powers under a new Public Investment Act, (Demos and the Health Foundation, 2025). However, in the absence of a model supplied centrally, the issue remains within the discretion of ICBs, together with their local authority partners.[12] What is required is a generic approach with broad-based support around which ICSs can congregate. One such 'non-ideal' framework, sufficiently flexible to accommodate an intersectional approach, is offered by the Marmot Review of 2010. Sir Michael Marmot is Professor of Epidemiology at University College London and leads the Institute for Health Equity. Through his health inequalities work for, *inter alia,* the World Health Organization and the British government, Sir Michael has created an authoritative framework of recommendations to reduce health inequality, starting with a focus on children.[13] In 2010, he identified the following six policy domains, i.e.:

(1) Give every child the best start in life,[14]

(2) Enable all children, young people and adults to maximise their capabilities and have control over their lives,

(3) Create fair employment and good work for all,

(4) Ensure healthy standards of living for all,

(5) Create and develop healthy and sustainable places and communities,

(6) Strengthen the role and impact of ill health prevention. (Marmot, 2010)

To this, two further areas were added in 2020 in the context of the SARS-CoV2 public health crisis:

(7) Tackle racism, discrimination and their outcomes,

(8) Pursue environmental sustainability and health equity together. (Marmot, 2020)

Each domain encourages a holistic perspective and provides an opportunity to take an intersectional approach to craft adapted solutions to more effectively account for complex experiences of health inequality. Now we need to develop the partnership arrangements required to support these objectives. These priorities have inspired over 40 local authorities across the UK to become 'Marmot Places,' which address health inequality by proactively engaging in programmes that embody the eight key areas. Practice varies as ICS' respond to local circumstances. Each 'Marmot Place' plans interventions for its local population to foster sustainable systemic change in the long term, though no external financial support is provided for them to do so (Dean, 2024). 'Marmot Places' and 'Marmot Cities'[15] and at a smaller scale, 'Marmot Boroughs' receive guidance from The Institute for Health Equity. The Institute supports local authorities to assess the extent of inequalities in their area and identify valuable existing initiatives and gaps in their programmes, to generate a plan for collaboration with local bodies (Dean, 2024). Although recommendations vary in scale and scope, the focus is always on initiatives that go beyond the delivery of healthcare services to address the root causes of inequalities. Acknowledging that the NHS alone cannot tackle the complex issues affecting population health, the 'Marmot Eight' principles set out to "develop and deliver interventions and policies to improve health equity; embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity" (Institute of Health Equity, 2024).

The 'Marmot approach' focuses on lived experiences to set priorities and build strong accountability locally and at the higher official echelons (Dean, 2024). Whether by interventions which target environmental, socioeconomic or behavioural factors, or access to health care and outcomes, the foundation for action is not an abstract theory of distributive justice. Rather, priority is placed on responding to the inequalities suffered by the most deprived and marginalised parts of the community based on the principles of proportionate universalism which seeks to make the scale and intensity of action proportionate to the level of disadvantage (Albini, 2024). For example, Coventry, a 'Marmot City' since 2013, has adopted policies that focus on reducing digital exclusion, making remote services more accessible, optimising transport for in person services, increasing pre-employment apprenticeships and work placements, and improving mental health, to specifically support young populations in its most deprived areas (Coventry City Council, 2024). Coventry's local authorities want all residents, including its most vulnerable, to have the opportunity to benefit from 'good growth', something they believe will generate jobs, better housing and other benefits to the city (Coventry City Council, 2024).

'Marmot Places' are good examples of pragmatic, non-ideal solutions at a local level. They offer a helpful framework to guide priority-setting to reduce health inequality. All Marmot areas seek to better integrate interventions to tackle health inequality by coordinating the work of local government, the NHS, the voluntary and community sectors, other public services (e.g., education, criminal justice and transport), and the business and private sector. They have the advantage of a flexible starting point about which there is widespread support and from which information about successes and failures can evolve.

CONCLUSION

ICBs have clear statutory duties as to health inequalities, so they must do something; the question is what? We have described how the NHS Constitution has promoted the notion of procedural fairness in priority setting. However, this is very different from the substantive duty to reduce health inequality. Certainly, the NHS and local authorities have a procedural duty to co-operate and integrate their services, but its potential for tackling health inequality is uncertain. In the absence of a national framework for action or coherent theoretical response, we endorse a pragmatic approach to the challenge of health inequality, grounded in the reality of the lives people actually lead. The 'Marmot Eight' principles offer a constructive response, at least for the present, not because they are 'ideal', nor because they are the only possible options. They are, however, manifestly plausible responses about which health authorities could unite and collaborate by sharing experience and learning.

Equally, we should acknowledge that corporate and mass media interests are always likely to resist change, arguing perhaps that interfering with individual lifestyle is an unwarranted, "nanny state" infringement of liberty by "food fascists" (Marmot, 2013; Le Grand and New, 2015)? For example, "climate change, obesity, drinking, smoking, gambling, and abuse of pharmaceutical opioids are overwhelmingly framed as poor individual choices: the problem gambler; irresponsible drinker…" (Gilmore et al., 2023; Paetkau, 2024). This may equally serve to deflect attention from governments' own failures to invest in population health (Deaton, 2013; WHO, 2024; Joseph, 2013; Chadwick, 2019). We have considered the position in England. In truth, however, the roots of deepening inequality are more widespread and lie in the power and influence arising from global structures that concentrate private capital and political influence in increasingly fewer hands (Picketty, 2020; Stiglitz, 2013; Newdick (b), 2016) and, correspondingly in the UK, the belief that austerity justifies faltering investment in public services relative to GDP (Ogden and Phillips, 2023). Short of a Polanyian transformation in the narrative about the value of public services to social solidarity (Polanyi, 1957; Wilkinson and Pickett, 2010; Mazzucato, 2018; Atkinson, 2015), productive policies to reduce health inequality will always face a steep uphill struggle.

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[1] Under the National Assistance Act 1948, Part III.

[2] On the meaning of the comparable duty of the Secretary of State to have "due regard" to the Public Sector Equality Duty in s 149(1) of the Equality Act 2010, see *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, [26] and at [61]: "advance consideration has to be given to these issues and they have to be an integral part of the mechanisms of government... There is a need for a conscious approach and the duty must be exercised in substance, with rigour and with an open mind…"

[3] *NHS Constitution* (DHSC, 2023), "You have the right to expect local decisions on funding of… drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you." This is given statutory force by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regs 2012, SI 2996, Part 7. Note, ICBs have replaced CCGs, see

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the National Health Service Act 2006 s 14Z25 *et seq* as amended by the Health and Care Act 2022 (Consequential and Related Amendments and Transitional Provisions) Regulations 2022, SI 634, reg 58.

[4] See for example, the Buckinghamshire, Oxfordshire and Berkshire ICB and Frimley ICB Ethical Framework, available here: https://fundingrequests.scwcsu.nhs.uk/thames-valley-priorities-committee/.

[5] National Health Service Act, 2006, s.14Z42 (as amended by the Health and Care Act 2022).

[6] National Health Service Act, 2006, 14Z38 (as amended by the 2022 Act).

[7] National Health Service Act, 2006, s.82s, (as amended by the 2022 Act).

[8] National Health Service Act, 2006, s.116Zb (4) and s14Z54(3) (as amended by the 2022 Act).

[9] National Health Service Act, 2006 s.75, s.65Z and s.75 (as amended by the 2022 Act)

[10] National Health Service Act, 2006, s.14Z55 (as amended by the 2022 Act).

[11] The DHSC has yet to fulfil its promise: "To support investment in prevention, NHS England and DHSC will work closely with ICSs, local government partners and NICE to develop practical information and evidence to support local investment decisions." (DHSC, (b) 2023).

[12] Note, we have yet to develop reliable ways of quantifying and comparing non-clinical, cross-departmental policies to reduce health inequality (unlike QALYs for health care *technology*), although NICE has published a repository of related guidelines concerning health inequality (NICE, 2022). See also Malcolm et al., 2023.

[13] For the first time since the creation of the NHS, it is reported that the average height of children is in decline in the UK, whilst the numbers suffering obesity and type 2 diabetes is increasing (Food Foundation, 2024).

[14] On the Sure Start programme, "…the programme was inequality-reducing from early childhood all the way through adolescence… driven by a significant increase in lifetime earnings from improved academic performance at age 16… If we were to consider the reduction in hospitalisations… children's social care provision and juvenile offending, the cost–benefit figures might improve even further" (Carneiro et al., 2024 at 43).

[15] In 2013, Coventry became the first "Marmot City" basing its planning on the findings of the Marmot Review (2010) to boost the health of its residents particularly those living in deprived areas of the city and young people.

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