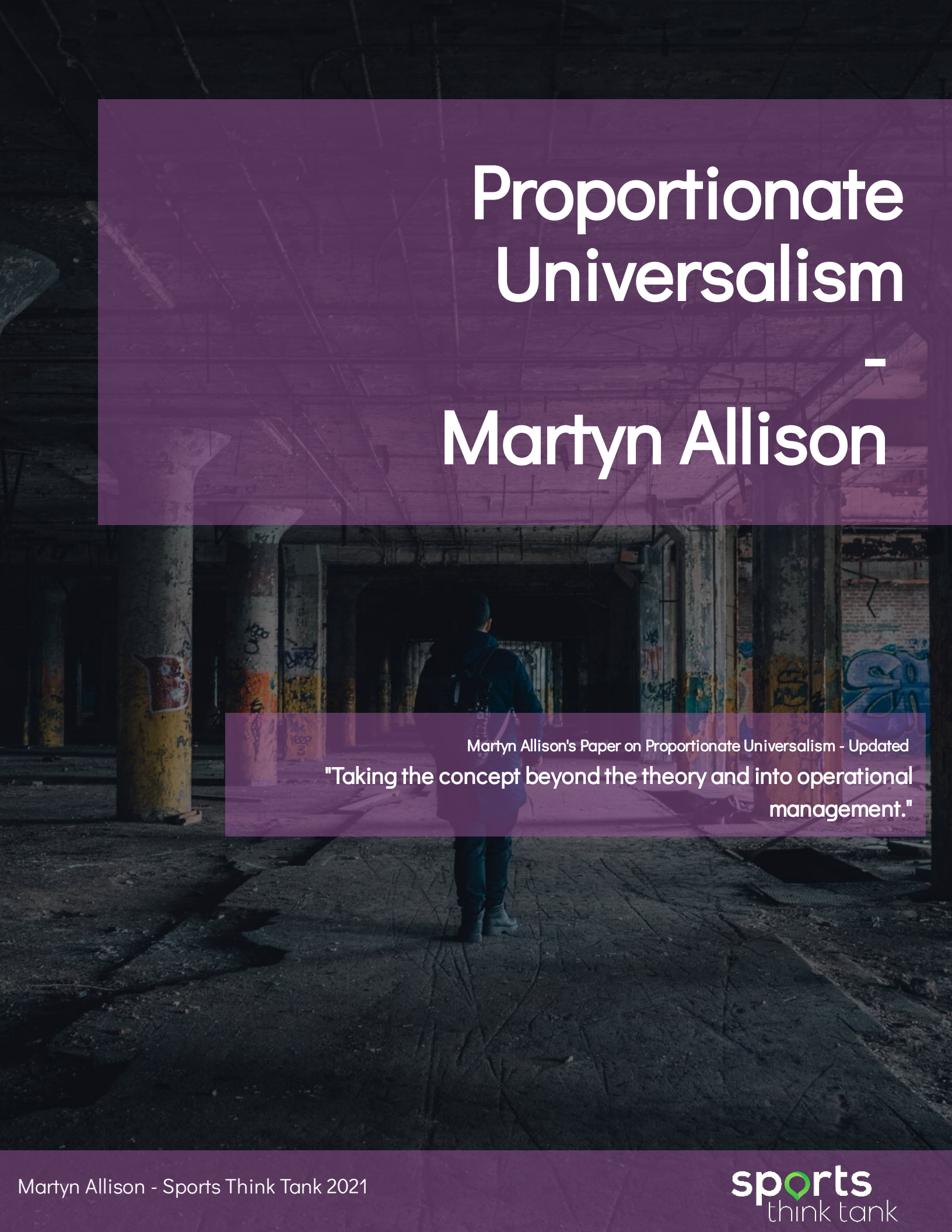

Proportionate Universalism - Martyn Allison

Martyn Allison's Paper on Proportionate Universalism - Updated

"Taking the concept beyond the theory and into operational management."

sports think tank

Welcome and Introduction

Welcome to this updated version of this paper from Martyn Allison. The concept of proportionate universalism is fortunately becoming embedded in the sport and physical activity sector narrative. But as Martyn has acknowledged in the conversations we have had since the publication of his first pamphlet, practitioners wanted to understand how to implement the 'theory' in practise. That's precisely why we exist - as a bridge between theory, evidence and implementation.

This update comes at a crucial time for the sector. The publication of the Sport England strategy, the potential ending of lockdown and the creation of a national recovery plan from the sector all mean that the future will look very different. We have been arguing for a long time that investment into the sector will need to look very different to tackle the long term and systemic inequalities that is exist in provision and outcomes in oursector.

The Covid-19 pandemic has particularly highlighted the health inequalities that still persist in our communities despite the spotlight of Marmont even a decade later.

This paper should not be read in isolation but in conjunction with the series of Blogs from John Oxley on the sectors messaging. Who are we and what are we trying to claim about what we can achieve?

I find as somebody who is deeply involved in the sector that I love its passion. But as I sit in other sectors too - economic development, employment, poverty reduction and international development, I know that passion isn't enough. We need good evidence and stories to tell and to be crystal clear about what we can achieve to tackle some of the biggest issues facing the country - and knowing our limits. I think a little humility sometimes around our contribution in the wider scheme of government policy making will really help. We cannot be the answer to everything but alongside others we can certainly help!

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Proportionate Universalism Updated

Midway through last year I wrote a thought piece on Proportionate Universalism which stimulated lots of interest and since the term appeared in the new Sport England strategy it has stimulated even more interest. However, from many conversations I have had it's clear that some people may have difficulty fully understanding what proportionate universalism actually means and as a result may be finding it difficult to apply the concept to operational management and policy making. As a colleague John Oxley remarked recently, just as there is a difference between pure and applied Maths, maybe there is a difference between pure and applied Proportionate Universalism. In a recent exchange I asked for views about the concept and everyone felt it needed a simpler clearer explanation and some offered suggestions.

"*Actions should be universal, not targeted, but on a scale and diversity that's proportionate to the level of disadvantage and need". Jon Argent.*

"*Providing and enabling physical activity interventions to a scale that reflects the level of inactivity in local communities". David Rushton.*

"*More assistance where needed, rather than equal access to assistance". David Monkhouse.*

"Change in health outcomes requires a whole population level approach, with specific engagement and support for disadvantaged and excluded communities, in a collaborative effort with agencies and communities". Dr Linden Rowley.

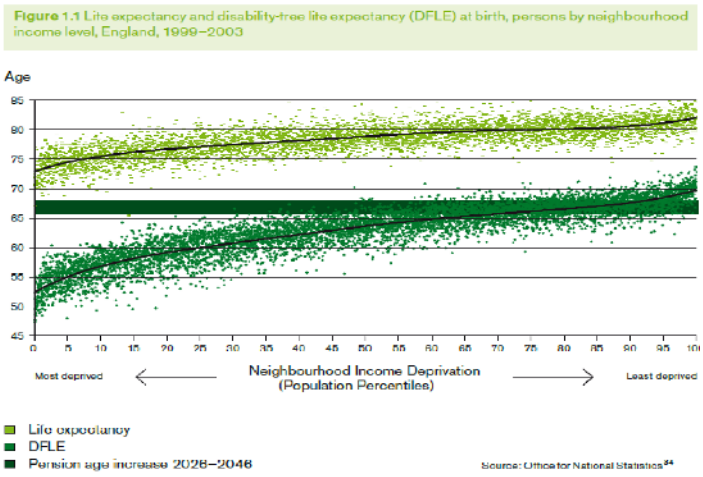
In this paper therefore, I have attempted to explain the concept in simpler terms and show how it can be applied to policy and operational management. I hope it helps your understanding.

Martyn Allison

March 2021

1. Michael Marmot and health inequalities

We have to start with Michael Marmot and his landmark report into health inequalities in this country in 2010. In 'Fair Society. Healthy Lives' his basic premise was that the richer you are, the longer you live by a factor of about 10 years. He also pointed out that richer people live a disability free life longer. As the pension age goes up, more and more people with health related disabilities find it limits their ability to work and their lifestyle earlier in their lives, so increasing the inequalities further. He concluded that we needed to address these health inequalities by reducing this gap between the richest and poorest. **The difference in health outcomes between the most deprived and the least deprived is known as the 'social gradient in health'.**



Marmot in his report concludes that these inequalities are not down to differences in health care, but due to deep-seated differences in the socioeconomic makeup of the population caused by what The World Health Organisation termed as the social determinants of health.

He identified that reducing health inequalities will require action on six policy objectives:

– Give every child the best start in life

– Enable all children young people and adults to maximise their capabilities and have control over their lives

– Create fair employment and good work for all

– Ensure healthy standard of living for all

– Create and develop healthy and sustainable places and communities

– Strengthen the role and impact of ill health prevention.

Marmot argues that in order to address health inequalities we have to change how the whole system works, education for life, meaningful employment, place-based quality of life and many other aspects which you can read about in the report. Although he doesn't refer directly to being active - it is implied in so much of what he says about enabling people to maximise their capabilities, taking control of their lives and strengthening the role of health prevention. We should therefore see ourselves as not THE solution to health improvement but just one very small , but vitally important cog in wider system change.

In 'Heath Equity in England: The Marmot Review 10 years on' (2020) Marmot reported that health inequalities had, in fact, widened since his 2010 report.

England is faltering. From the beginning of the 20th century, England experienced 'continuous improvements in life expectancy but from 2011 these improvements slowed dramatically, almost grinding to a halt. For part of the decade 2010-2020 life expectancy actually fell in the most deprived communities outside London for women and in some regions for men. For men and women everywhere the time spent in poor health is increasing. This is shocking.' *(Marmot 2020).*

Later in 2020 Marmot addressed the impact of the pandemic on these inequalities in his report 'Build Back Fairer: the Pandemic, Socioeconomic and Health Inequlities in England' Marmot points out that COVID 19 related deaths follow the same socioeconomic patterns as pre-pandemic differences, and that the effect of the virus across the life-course is exacerbating pre-existing inequalities.

As the UK emerges from the COVID-19 pandemic it would be a tragic mistake to attempt to re-establish the status quo that existed before – a status quo marked in England, over the past decade, by a stagnation of health improvement that was the second worst in Europe, and by widening health inequalities. That stagnation, those social and regional health inequalities, the deterioration in health for the most deprived people, are markers of a society that is not functioning to meet the needs of its members. There is an urgent need to do things differently' (Marmot 2020)

2. Proportionate Universalism

In his 2010 report Marmot introduced the concept of 'Proportionate Universalism'. This challenged the urban renewal policies of the previous two decades where 'additional' monies were targeted towards the most deprived communities. Further, he argued that **to address the deep-seated inequalities required using the totality of resources in a concerted way, rather than 'additional' pots.**

"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."

Traditionally, public policy often called urban renewal has attempted to deal with communities living in multiple deprivation by focusing only on them. Often by applying additional resources into those communities over short periods of time, 3-5 years, the hope was to change their lives, improve their education, ability to get a job, where they live, their environment, their health and try to give them more confidence to improve their own lives.

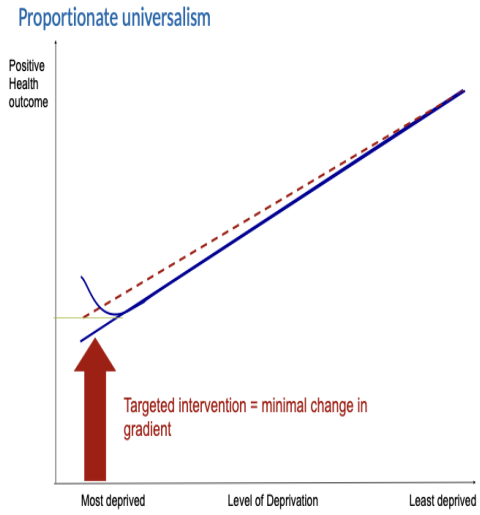
Meanwhile, at the same time, the rest of the system which was responsible for much of their disadvantage and exclusion continues to behave in exactly same way, so when the "experiment" is over and the funding stops everything just goes back to exactly as it was before. When the experiment is over, those who have been the focus of this attention simply feel let down. For them nothing has really changed but they do feel like they have been labelled and stigmatised by the process and made to feel that the position they are in is all their fault.

Our Urban Landscape and Place help determine our activity levels

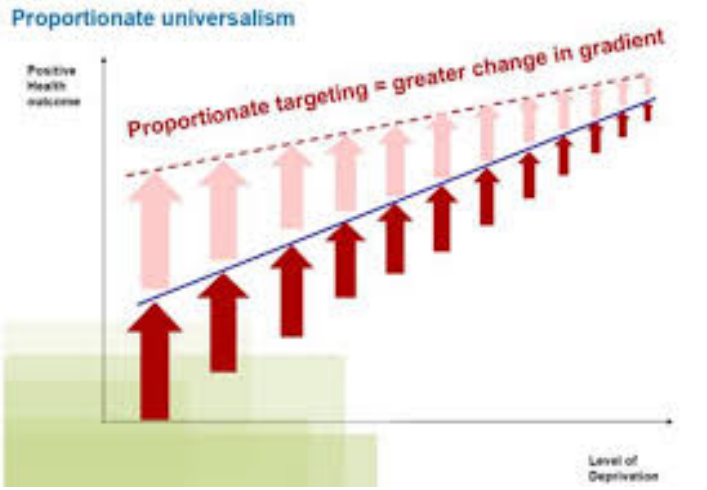
Because the experiment takes place within specific communities often described by geographical boundaries, those living just the other side of that boundary but suffering many of the same disadvantages also feel an even greater sense of unfairness. Why have *'they'* got the extra money and not '*us*'? This in more extreme situations can create real tensions between communities causing councillors and service managers to try and explain the perceived unfairness or address it by moving other resources to improve the tension but then causing more resentment in the next community. If the intervention does work, and some interventions have successfully addressed some of the disadvantage but the rest of the system fails to learn from the experiment and change the way it works, the same problems simply reoccur elsewhere creating the case for yet another major intervention in a different community and so the whole process starts all over again because nothing has changed.

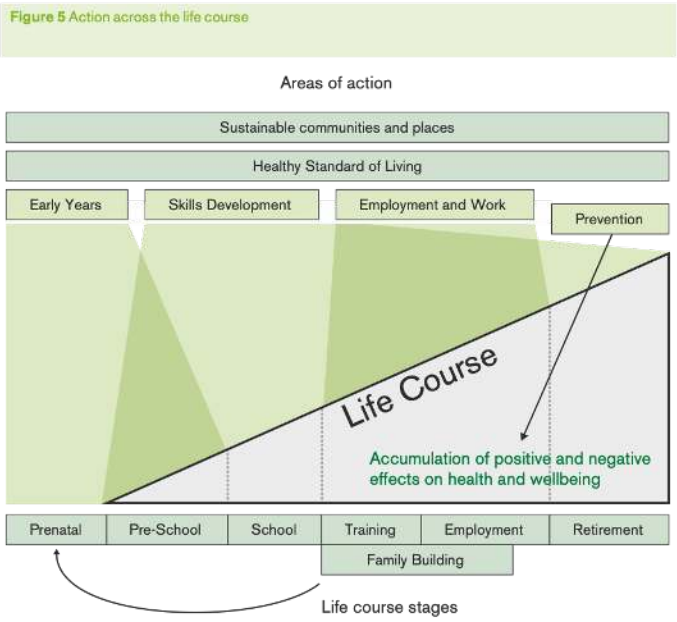
In short, the shortcomings of these externally funded targeted interventions include:

- they fail to address the problems in a holistic way involving the whole system and the totality of resources
- they miss communities considered 'not quite deprived enough'
- they don't recognise the complexities of communities where wealth and poverty may exist side-by-side, where some individuals may be asset rich and cash poor, where issues of physical and mental health, loneliness and other forms of exclusion are hidden below the surface
- they risk stigmatising communities, suggesting they are poor because they have made poor choices, rather than that they make poor choices *because* they are poor
- without detailed insight, they can miss the fine grain 'lived experience' of communities.



Targeted intervention creates only minimal change to the gradient. To counter this historical failure, Marmot argues that to address the inequalities we have to work universally across the whole gradient and across the whole life course, from the very young to the very old. By doing so we improve everybody's life expectancy but reduce the gradient and narrow the life expectancy gap by applying "more effort" and "greater intensity" where deprivation is highest. **This involves system thinking, system change and involves leading collaboratively.** It will mean some behaviour change in individuals and communities but more importantly, it means behaviour change in us across the system.



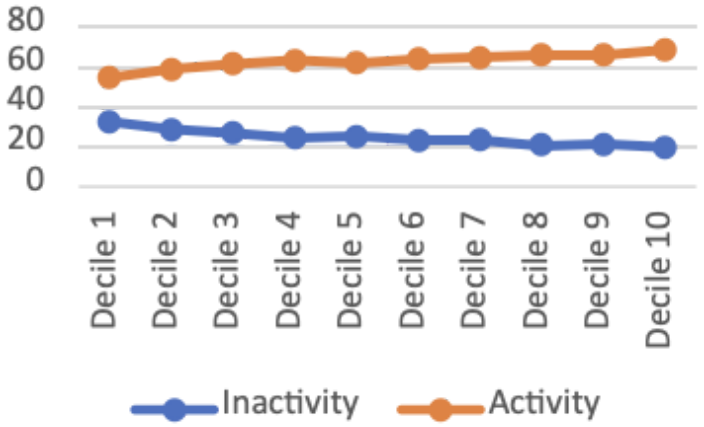


3. How can we apply Proportionate Universalism to sport and physical activity?

In previous articles I have tried to explain how we have found it difficult to address inequality in our supply of sport and physical activity opportunities for over forty years since the Sports Council first launched the 'Sport For All' campaign. Under-representation among certain groups has always existed whether we measured use, participation or activity and we seem to find it very difficult to change this position. However, if we examine our approach over the last forty years we see the same pattern we have seen with urban renewal policy. We have labelled people as "targets" because we feel they are hard to reach, disabled people, black and ethnic minorities, women and geographically we have labelled some communities as deprived. As Tim Hollingsworth was told recently by a community leader "we are not hard to reach, you just haven't looked hard enough" or words to that effect. Indeed, many communities feel that public institutions are for them hard to reach.

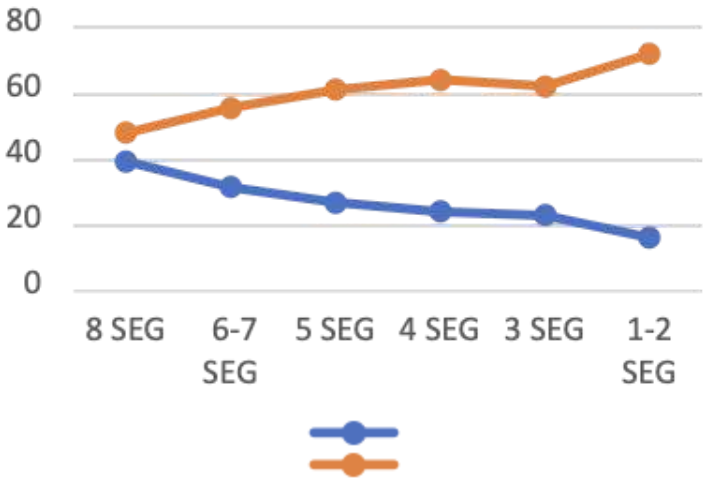
We have never really considered before how this labelling has made them feel or shown real empathy for what it must be like to live in their shoes. We have allocated short term top up funding to projects that intervened in attempting to change their behaviour as if there is something wrong with their behaviour, calling this sports development or outreach. Meanwhile the rest of our system, the leisure centres and sports clubs have continued to operate in much the same way as they always have, providing for their same audiences who are most 'like us'. Research evidence suggests these so-called target groups have similar reactions to being experimented on, becoming more and more disillusioned as the short term resources come to an end and nothing in the system had really changed for them. We also know that when resources got tight it was always the sports development functions that are reduced first. Through the most recent period of austerity, much of the community based sport development work has either disappeared altogether or found itself rolled up into Active Partnerships or into facility management contracts, sometimes even competing with each other.

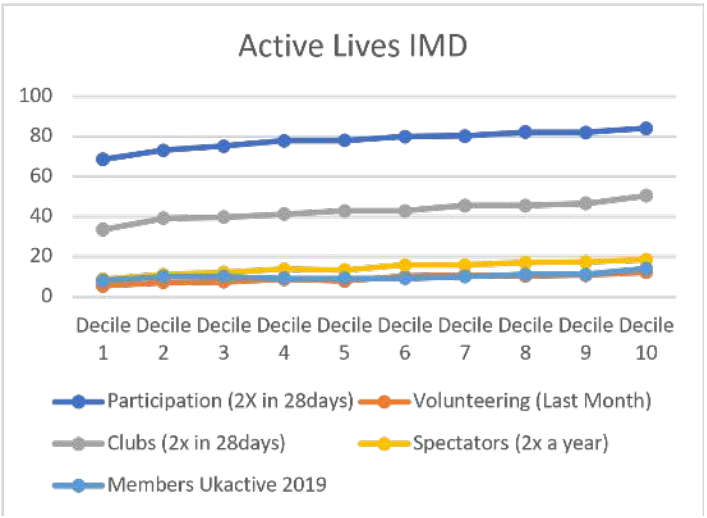
In my first paper on Proportionate Universalism I focused on the world of facilities as the one I knew better and where there was an ample data to demonstrate the nature of the challenge. The first two graphs include data from the Sport England Active Lives surveys that measure people's activity levels and inactivity levels against the same measure used by Marmot e.g. deprivation (IMD) and also against Socio Economic groups. You can see, as we would expect they follow the Marmot life expectancy graph e.g. the richer you are the more active you are and the poorer you are the more inactive you are.



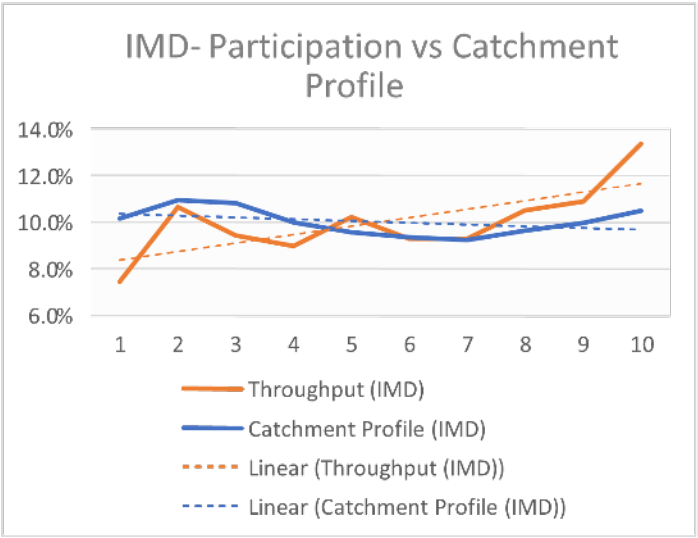
The following graphs also shows the same pattern with general participation, playing sport in clubs, volunteering and even spectating also falling away from the least deprived to the most deprived.

Activity and inactivity SEC





Finally, the next graph, courtesy of DataHub shows an analysis of usage by deprivation in 2019 using data from 908 sites that provided consistent data across a full 12-month period including over 93 million visits from 3.4 million individuals. The orange line shows participation levels by deprivation levels (IMD) and once again the line falls from the least deprived to the most deprived. The blue line is the % of catchment population (15min drive time to the sites in the sample) by IMD group. The two lines cross roughly in the middle at IMD 5 so to the right of where they cross usage is over-representative of the least deprived communities and to the left of the where they cross usage is under-representative of the least well-off communities. (The two dotted lines are trend lines for throughput and catchment population.)



Further evidence has recently emerged in research carried out into The Contribution of Leisure Center Usage to Physical Activity in the United Kingdom: Evidence From a Large Population-Based Cohort, published in 2021. The research concluded that:

"In this large population-based study, our results demonstrated that the provision of local authority leisure centres contributed a median of 55.0 minutes (IQR: 30.0–99.0) of moderate/vigorous LTPA per week to the recommended ≥150 minutes of moderate/vigorous PA per week. This means that local authority leisure centre members achieve approximately 1/3 of the World Health Organisation's recommended 150 minutes of moderate/vigorous weekly PA12 through leisure centre use. This is an important contribution, which should be combined with an encouragement for users to be active in other environments to achieve the recommended levels of PA. Importantly, our findings identified that being female, being older, and attending a large leisure centre significantly increased the odds of achieving a higher category of PA (30–149 and ≥150 min) compared with undertaking <30 minutes of activity per week through leisure centre–based activity.

They also found that:

"Those from more deprived areas were less likely to access the local authority leisure centres. As those living in more deprived areas have potentially less disposable income, it is possible that price is a contributing barrier to access, but we were unable to examine the effect of concession pricing since the trust made changes to their concessionary access scheme in the period covered by the data extract. This was further complicated by the way that memberships were tagged in the FDS, with the term "concessionary" applied to any discounted membership, rather than just to those on low incomes or who were registered disabled. Pricing in the local authority leisure sector to encourage use by targeted groups is complex. Quantitative studies have reported that offering free memberships can increase participation but that if free use is removed, then usage is not always maintained. Of interest in the current study, the majority of exercise referral usage was on a pay-as-you go basis. Given that those who took out prepaid/monthly memberships used the centres for a much longer period of time, the leisure trust should explore how to encourage a move from pay as you go to a prepaid/monthly membership for this group as it may have the potential to improve retention. A caveat for this must be that pricing strategies do not exclude those in who are in the lowest income brackets

Qualitative evidence indicates that navigating the competing pressures of providing services for the public "good" and remaining commercially viable make pricing decisions difficult and that pricing is only one barrier to accessing facilities

We acknowledge the complexities of the interactions between concessionary pricing and commercial viability; however, where concessionary pricing schemes exist, they must be clearly defined and accurately tagged within the FDS to enable future examination of the effectiveness."

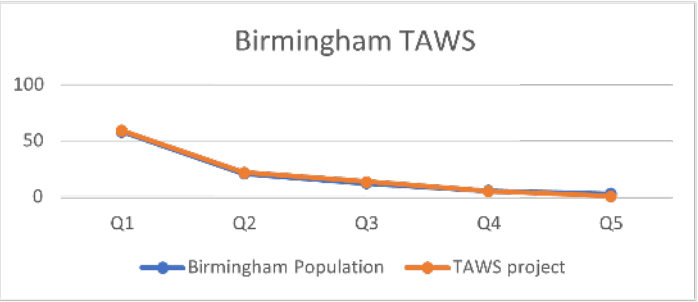
The usage data shown in the report shows the identical pattern as the graphs above namely over representation from the better off and under representation from the least well off and the impact of membership and pricing schemes both on accessibility and impact analysis.

Putting all this together there is a clear but not unexpected narrative, that whilst facilities have a major contribution to make to maintaining and increasing activity levels they and other aspects of participation in sport and activity all reflect Marmot's patterns of health inequality

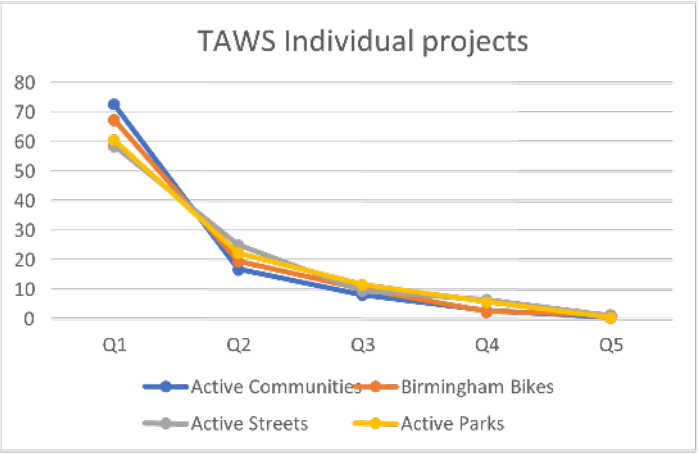
Not only does engagement fall from the richest to the poorest, but we also see over representation among richer communities and under representation from the poorer communities, with the biggest gap among the very poorest and least active. ***To put this more bluntly, just as we have continued to advocate louder and louder that doing sport and physical activity improves your health, we are actually also contributing to making health inequalities worse.***

There are however many examples across the country where attempts have been made to address these barriers by applying targeted action but few that really embrace the Proportionate Universalism model. One example that perhaps got closest is The Active Wellbeing Society who are working with the most deprived communities in Birmingham. Originally part of Birmingham City Council Sport and Leisure services they started their work on 'Be Active' 10 years ago by providing free access to leisure facilities using the principle of proportionate universalism.

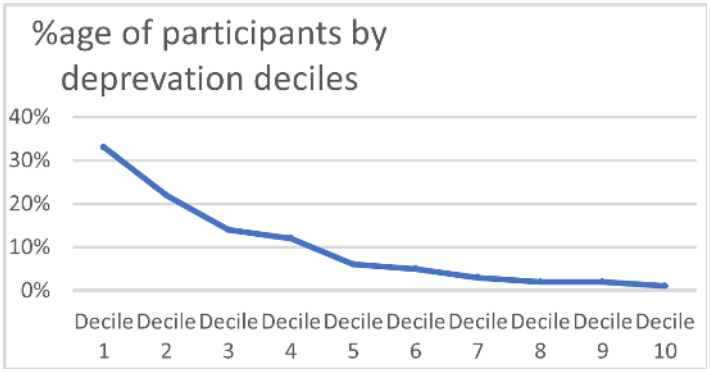
Birmingham still has some of our most deprived communities in England and huge health inequalities. At the time, extra funding from Public Health and the City Council enabled every city resident to join a free membership scheme giving access for everyone to some free time in leisure centres. However, the amount of free time varied across the city with the level of local deprivation so providing a Universal Service to improve everybody's health but providing the amount of free access proportionate to need. At those free times the price barrier, the known biggest barrier for these poorest communities was removed but as independent evidence showed **the overall impact of the scheme on the city was the generation of significant system-wide savings of over £21 for every £1 invested.**



When the council transferred its facilities to outsourced operators in 2017, the Be Active free time arrangement was included in the contract. TAWS itself left the council two years ago and was established as a community benefit society to continue the work they started in the council. Every project that they run, Birmingham Bikes, Active Parks, Active Streets as well as the original BeActive scheme is run on the same principles but co-designed with local communities. As well as using IMD as one of their metrics, they also measure themselves against the population demographics of the city to ensure they are representative of the population they serve. Whilst price barriers have been removed at certain times and access barriers have been minimised by local interventions, it is the extra effort made to engage and work with communities that has also made the difference. If you look at the following graph you see is that is very different to the others above with usage representative of Birmingham communities.



Another example is StreetGames, a sport for development charity which operates to support children and young people mainly from the most deprived communities all over the country. Its latest participant profile data shows that although most sessions are 'open access', they are specifically located within areas of high deprivation and designed to be accessible for those in greatest need and so share many of the same cultural and leadership traits with The Active Wellbeing Society. Although this project reflects a more targeted approach, where location is a key factor in the delivery, they do show that by applying greater effort in certain communities you can get more engagement proportional to need.



The juxtaposition of these two projects with the data from mainstream facilities shows just how difficult it is to deliver a service that is both universal and proportionate to need without an increased level of funding from councils and other partners such as health to help address the under-representation and particularly to overcome the price barrier which means **health inequality cannot be addressed in facilities alone but only across the whole system.**

4. Is a pandemic the right time to do this?

During a decade of austerity, many councils have driven a very 'efficiency-led' procurement process which has further commercialised the service delivered through facilities so much that gradually council subsidies have been reduced, often completely and in some cases replacing it with substantial financial returns going back to councils. This has been used to fund the capital refurbishment/development costs of new facilities but also to fund other council services including sports development / outreach.

There have been recent attempts to improve leisure services procurement and partnering to ensure a more balanced approach to price and quality with a greater focus on effectiveness. This improved approach is now being led through Sport England's soon to be released Leisure Services Delivery Guidance for all management models.

In this very competitive market, some operators have been able to retain a focus on equality by using increased income from the more better-off users to cross subsidise targeted projects and programmes for the less well-off and under-represented groups.

In addition, some contracts still include 'legacy' concessionary pricing schemes that remain under the control of the council which may have remained unchanged for years without any calibration to local health priorities or changing community needs. In addition, to enable the sustainability of contracts we have built a system that now relies more and more on gym and group fitness and direct debit membership schemes instead of 'pay and play' in order to maximise income and cash flow which together have driven operators further towards the better off and away from the least well off.

This more commercial approach alongside the building of new more efficient facilities has undoubtedly created significant growth in use enabling us to demonstrate a growing impact in terms of social value including health benefits. However, this value is mainly being measured from membership data generated largely from the active and better-off users rather than measuring and evidencing the health impact on the poorer, inactive and those with the greatest health needs.

This would partly explain why many health commissioners view us as being more interested in making the already active more active than seriously addressing inactivity among their priority groups.

At the same time these membership schemes have helped create new barriers by separating access to the universal services for those able to pay from the targeted services for those that cannot. There would be nothing wrong with this differentiated approach if it has been more proportionate and if it had lead to increased activity levels among the most deprived communities.

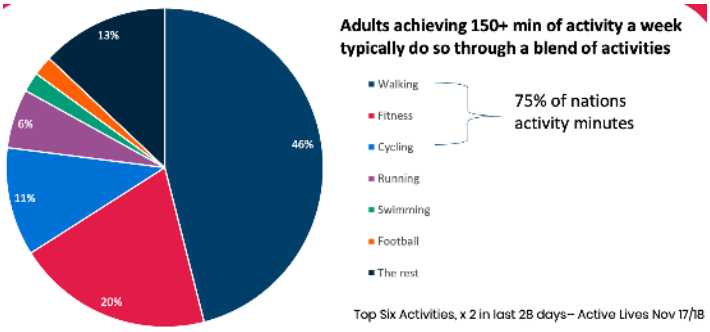
When I first raised the need to apply Proportionate Universalism the reaction was that it was perhaps the wrong time, given the financial impact the pandemic was already having on the operation of facilities, but that once we have recovered it should be addressed. As a result, many operators and trusts perhaps see the term Proportionate Universalism with some trepidation and fear because they think it will require them to generate more usage from the less well-off without any financial support from councils to do so. Offering more free or low price activity would be seen as high risk before the pandemic, but to be asked to do this now when the pandemic has already devastated their business becomes even more unthinkable.

In many ways they are, of course, right and just as Birmingham had to invest more resources in BeActive in order to get the wider health benefits across the system, so other councils will have to do the same if we want to use their facilities to address rising health inequalities in a Proportionately Universal way. But even in Birmingham as resources have been reduced, there have been more and more constraints applied to the free access arrangements which now runs alongside traditional concessionary pricing and traditional membership schemes. This demonstrates that a real shift in thinking is now required to enable councils, operators and in some cases consultants to address this problem together and **instead of seeing their facility contracts as 'cash cows', to see them as an important means of sustainably improving the opportunities to be more active for those in greatest need.**

But whilst price and cost are key factors in addressing this problem in individual facilities, they are not the only barriers that we need to address. Operators and trusts will also need to look beyond their own facilities and contracts and consider the challenge of inactivity across a wider canvas of place.

5. Looking beyond facilities and across the place

We cannot address the challenge of inequalities in activity by focusing only on leisure facilities, sport clubs and gyms. As the following graph shows although sport and fitness is important the vast majority of people get their exercise by walking and cycling in informal settings or through their commuting which is why in order to address health inequality we need drive change across the whole system.



The challenge could become so much easier if we were to work together and engage all the providers in a place to tackle inactivity together. Many operators have multiple sites servicing different communities and there will also be multiple sport clubs operating in and with different communities alongside many non sporting community organisations also offering opportunities to be active.

By doing the same population mapping exercise together across a place i.e. a village, a district, a town, a city, a county we can then compare the usage patterns for all the providers and see where the gaps in representation are and agree how and who might be best placed to address the gaps. Together we could decide where more effort is required and where any additional investment should go to make the biggest impact on increasing activity. This might mean more subsidy to particular leisure centres, improving parks or supporting specific community organisations or sports clubs. However, it might also mean choosing to generate more income from some facilities in order to fund investments elsewhere in the system so **requiring less competition and more real collaboration and leadership.** This would mean not only working together as a sector but working with other partners including environmental and transport planners, providers of parks and open space and health colleagues to achieve wider system change.

It's encouraging to see Sport England's Strategic Outcomes Planning guidance published in 2019 and in the process of being reissued along with increasing insight from learning from Local Pilots being used to support councils in undertaking this approach.

6. Changing how we work

The pandemic has changed everything and we cannot go back to how we use to work. The services we provided will have to be provided differently given the former business model is likely to be even less sustainable. At the same time the health needs of the country have also changed and health inequalities are already getting worse, so there is no better time to change the way we work by engaging with and adopting Proportionate Universalism. **As Marmot says, there is an urgent need to do things differently.**

Durka Dougall in a recent article 'Taking your approach to population health and tackling health inequalities to the next level' talked about how leaders can improve population health in their area by applying three levels of practice.

1. "The starting point is to recognise that whatever role you are in, you can make a difference. So, take time to consider your role, organisation or sector: what are you doing well already? What else is needed? Given that population health has a dual focus on improving health and reducing health inequalities, consider also: who are the vulnerable people and communities you are reaching and not reaching in your efforts?

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2. "The next level of working is to gain better understanding about your population, including the inequalities that exist, and about the numerous resources you can use to support this work. It's important to remember that the data is not an endpoint in itself, but an enabler. Pay attention to how you approach data collection and ensure it is done in a way that builds partnerships and engagement rather than focusing on just the numbers. Indeed, this can often be more important than the data itself!

3. Beyond this, those leading deep-reaching and meaningful change efforts often report that it is the relationship with the communities themselves that matter for population health and tackling health inequalities – the notion of not 'doing to' but 'leading with' and being 'led by' staff and communities.

We can apply this same approach to sport and physical activity by first recognising we can make a difference by starting with those we are reaching and not reaching. Although there are some places like Birmingham with significantly high levels of deprivation, most places will have varying socioeconomic differences across their populations so not every challenge will require the same level of intensity.

The starting point is to define the shape and makeup of the local population we seek to serve. In terms of a single facility it might be the catchment profile within a 15 minute drive time as shown on the DataHub graph earlier by the blue line. But why drive time, this immediately defines your primary audience as car owners or the car accessible? Why not walking time or public transport journey time? This is important because we know that accessibility and access like price are primary determinants of engagement. Once the catchment area is defined we need to know the socioeconomic profile of the population in that area and then how it compares to the user profile, the red line on the DataHub graph.

Although membership schemes create new barriers, they do provide valuable data about usage which is why in Birmingham they gave everyone free membership of the BeActive scheme to enable them to also measure take up, usage and impact. Then just as on the DataHub graph you can plot where under-representation is occurring which then becomes the focus of the more intensified effort.

For those operating in higher deprivation communities the gap between the population and user profile could be very significant and will almost certainly need greater financial investment from councils and health partners but for others the gap may be less of a challenge and quite manageable with better applied effort. **Marmot is not in any way suggesting that we reduce the gradient of health inequality by taking services away from the higher socioeconomic groups and making them less active and less healthy,** but by flattening the gradient by applying more effort where the need to be more active is greatest.

Of course this same thinking and data analysis should also be applied to other demographic differences in order to address the other aspects of under representation among women, black and ethnic minority communities, disabled people and people with specific health needs, some of which will directly overlap with the socioeconomic deprivation, but not always. On the same basis we are not being asked to make white men less active and healthy but make other sections of our communities more active by applying that extra effort and support.

Proportionate Universalism is not an 'either/or' choice about who we work with - it is about being universal and helping everyone to improve their health. It is about providing facilities and opportunities for those readily able to access them and at the same time reaching those in our communities for whom access is currently a closed or partly closed door.

7. Changing our own behaviour before we can change other people's behaviour

Other than addressing price and accessibility through greater collaboration there are other actions we need to apply in order to help change how the system works. Recently Public Health England published a report on 'Understanding and addressing inequalities in physical activity' (2021). The report presents the findings of a study conducted at the University of Derby which aimed to further understand levels of inequalities in physical activity across and within certain characteristic groups. The report uses a review of evidence to identify the key factors that affect the rates of inactivity in specific under-represented audiences including those with different health conditions. This is a good starting point from which to consider what interventions might be required where specific under representation has been identified in the analysis of place or individual facilities.

They then use this evidence base to identify what may be the most common factors across most groups and bring these together under three themes:

- enablers, barriers and identifying opportunity

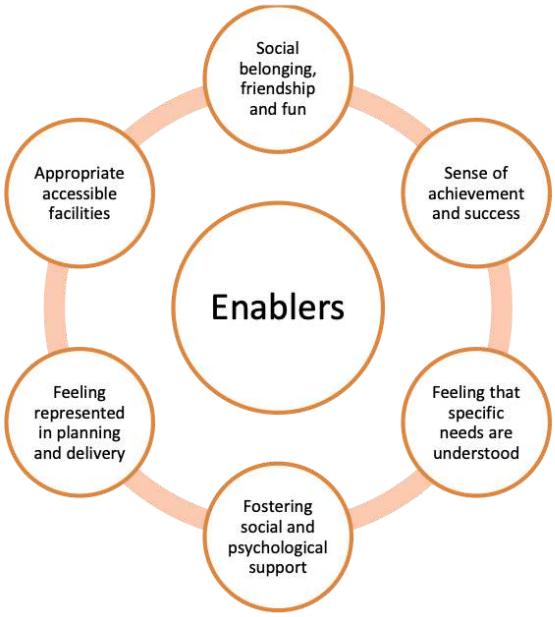
- community consultation, engagement, and partnership
- holistic approaches towards protected groups and combined discrimination

As we are also learning from the work of the Local Delivery Pilots. They conclude that:

"***interventions should be fluid to meet practical, environmental, social, and psychological needs aligned with better understanding of demographic data to ensure intervention design is done in direct consultation with the community to ensure interventions are needs driven.***"

In other words, there is **no standard marketing approach, no one size fits all solution and some of that intense effort Marmot says is required involves greater engagement, better consultation and communication and more co-production**.

The following diagram describes those enablers that were most common across all the groups and many of these can also be found in the recent LDP learning report 'People and Places' (2021) and also found in the work of The Active Well-being Society and Streetgames. These are all about behaviours, **not of those inactive but us, the providers, and about our organisational culture and leadership styles**. These enablers are not about what we do but how we work.



The challenge is how we transpose some of the learning, mainly from the more community based settings into the facilities setting and the more traditional sport settings wherever issues of under representation exist. **Doing this raises some challenging questions about the diversity of our workforce in terms of generating greater awareness, understanding and empathy with those currently feeling excluded but also raises questions about how we train our workforce to be more able to apply this learning in different settings.**

It is worth remembering the saying 'if you always do what you've always done you will always get what you always got' and the new Sport England strategy 'Uniting the Movement' points the way to doing things differently. For forty years we have struggled to address the inequality issue in sport and physical activity and in that time there have only been marginal improvements. Although in this paper I have shone a light mainly on facilities, many of the same challenges exist in other parts of our sector, sports clubs, school sport and elite sport so the challenge is about system change. But we must not just blame the system for this failure. As Ken Masser, CEO of the Rossendale Leisure Trust and one of the Local Delivery Pilots pointed out recently ***"the system isn't a thing, it's just people like us"*** so when we need to change the system it's the behaviour of people that we need to change and we must start with ourselves.

8. Where do we start?

We are still in the middle of the pandemic and the social, economic and political impact of what is still happening will be with us for years to come. Understandably the focus of attention is on creating financial stability and then on recovery. The government, councils and Sport England have invested heavily in trying to shore up the sector but it was never going to be enough to protect everything. To date much of the investment has gone down separate and traditional routes with some going into facilities through councils and the National Leisure Recovery Fund, some going to sport clubs, some to support activity in schools and some national support going to private business. Whilst this is all critical to survival and the protection of services, jobs and infrastructure I wonder how far all this investment will actually facilitate longer term sustainability and better equip us to deal with the health challenges ahead?

The message I hear most loudly is that we must recover first before addressing the changes we need to make. Why not make recovery the process of change? Is it not both more efficient and effective to create something that works better now?

What if we were to stop channeling all these individual funding streams down separate 'repair' routes and instead created one pot to invest in a place in order to start now to redesign the system so that it can "Build Back Fairer"?

What if we applied the learning we have from the LDPs and other system change work to facilitate that redesign process?

What if we encouraged councils to renegotiate and better fund their leisure contracts so that they made a real difference to their health inequalities?

What if we collectively made a much more strategic case to government for this pot to be expanded through the health recovery programme and then integrated into the new integrated care systems?

What if we showed real leadership and addressed inequalities once and for all?

9. Conclusions

1. You cannot understand proportionate universalism without first understanding Marmot, health inequalities and the social determinants of health.

Addressing health inequalities requires whole system change and that includes the sport and activity sector. It is absolutely worth revisiting the three Marmot Reports cited here, even just the key messages, to fully grasp the scale and severity of the health inequality challenges and the routes out of this.

2. **Health inequalities cannot be addressed by focusing just on the most disadvantaged through limited and short term interventions**. To narrow the gap and reduce the gradient we must adopt proportionate universalism and carry out actions that are universal across the whole population but with scale and intensity that is proportionate to need

3. When we look at the performance of many of our sport and leisure facilities, and probably other sport provision also, we unfortunately find that although we justifiably shout louder and louder about the contribution we make to improving health, **the evidence suggests we are actually contributing to making health inequalities worse.**

We can address this by focusing more on those in greatest need in an appropriate way that does not stigmatise or label and look again at how we use membership schemes and concessionary pricing mechanisms so that they both improve accessibility and provide better impact evidence relevant to health inequality.

"Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need"

— Understanding and defining Proportionate Universalism 2021

4. The scale of the challenge in each facility will depend on the scale of the under representation in usage. Where levels of deprivation are high, but in less challenging situations the scale of change required may be more manageable and achievable with more intense effort by operators and partners. **To do this we will need to provide robust evidence of the health benefits that will accrue, the cost benefits and social return.**

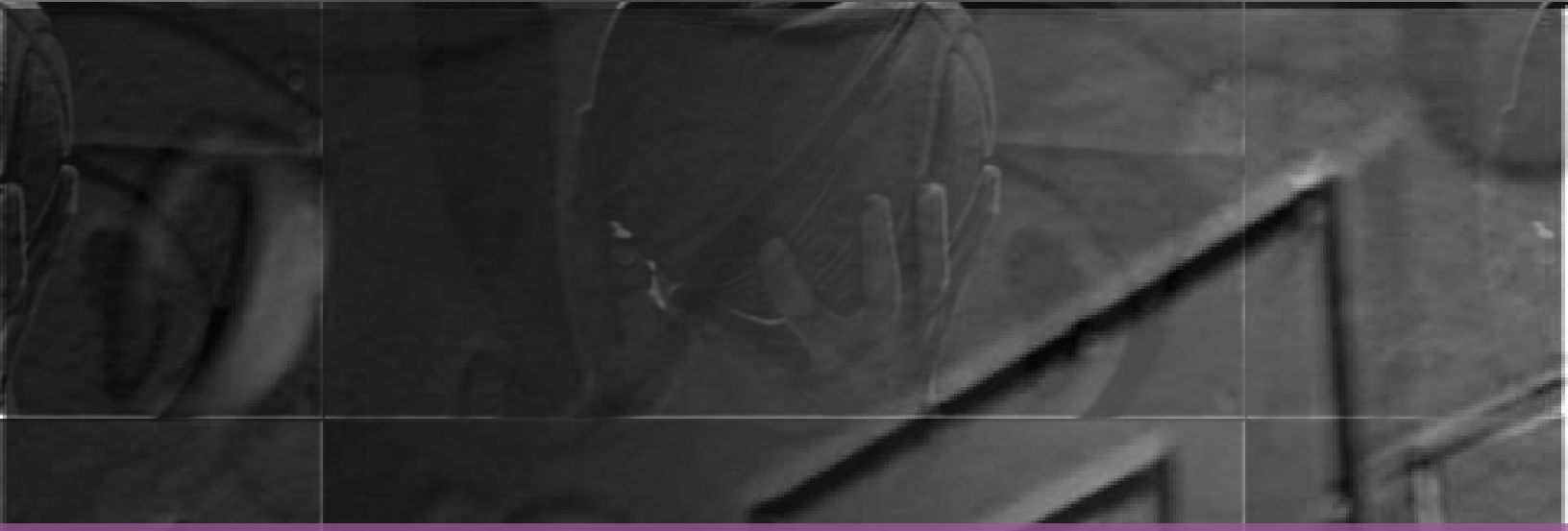
5. **The intensity of effort required will be made more efficient and effective if shared between all the potential providers and assets in a place.** This will require very different styles of collaborative leadership involving facilities, sports clubs, community organisations, parks and open spaces working together with others responsible for creating more active environment to change how the whole system works. In places where whole system approaches are developing, this approach involves working much more widely across the public, private and voluntary sector, with blended teams and devolved leadership across the system, based on a place and with intense insight and engagement with local communities.

6. **Price and access may be critical barriers to greater activity but not the only ones**. Every under-represented group and individuals face different, and sometimes unique, barriers which need to be identified by better understanding the data, better engagement and consultation and the co-production of fluid services that meet their needs. This is the more intense effort that Marmot believes is required if we are to address health inequality. But remember, **the system we need to change is not a thing, it's a collection of people like us who need to show more empathy and change our behaviour first.**

7. We have a great opportunity now by stopping channelling the short term resources available for recovery down separate traditional routes and **bring them together to create integrated funding to enable places to redesign now how their local system works so that recovery means 'Building Back Fairer'.**

Martyn Allison. March 2021.

With thanks to Dr Linden Rowley, Karen Creavin and John Oxley for their support and critical challenges to my thinking.



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