INSTITUTE of HEALTH EQUITY

KENT MARMOT COASTAL REGION
DATA-LED REPORT

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Ashford District Council

Canterbury City Council

Department for Work and Pensions

Dover District Council

East Kent Health and Care Partnership

Folkestone & Hythe District Council

Kent County Council

Kent Housing Group

Medway and Swale Health and Care Partnership

Swale Borough Council

Thanet District Council

GLOSSARY

BUA – Built-Up Area

CMO - Chief Medical Officer

DfE – Department for Education

DWP – Department for Work and Pensions

EPC – Energy Performance Certificate

FSM – Free School Meals

HCP – Health and Care Partnership

IDACI – Income Deprivation Affecting Children Index

IHE – Institute of Health Equity

IMD – Index of Multiple Deprivation

KCC – Kent County Council

KPHO – Kent Public Health Observatory

LSOA – Lower-layer Super Output Area

MHCLG – Ministry of Housing, Communities and Local Government

MSOA – Middle-layer Super Output Area

OHID - Office for Health Improvement and Disparities

NEET – Not in Education, Employment or Training

ONS – Office for National Statistics

PIP – Personal Independence Payment

UCL – University College London

VCFSE – Voluntary, Community, Faith and Social Enterprise

EXECUTIVE SUMMARY

Across the country, health is deteriorating and health inequalities are widening. In more deprived communities, people live shorter lives and spend a greater proportion of those years in poor health. Everyone below the highest socioeconomic group live shorter lives and experience worse health. This entrenched pattern – known as the social gradient – is evident nationally, regionally, and within Kent itself.

Most of the factors shaping health and these inequalities are outside the healthcare system and have their origins in the conditions in which people are born, grow, live, work and age. These 'social determinants of health' drive unfair and avoidable differences in life chances and a range of outcomes, including health throughout life. While there is no overarching national strategy focused on reducing health inequalities, there remains much that can be done at a local level. The University College London (UCL) Institute of Health Equity (IHE) works with places across the UK to identify where progress is needed to achieve health equity and to develop a system that prioritises and embeds this goal locally and sustainably.

In 2024, Kent commissioned the UCL IHE to support in becoming the first Marmot Coastal Region. This programme takes a proactive approach to tackling health inequalities by embedding multi-level system change. This encompasses decision-making at the top level, aligning systems for work and skills at the middle level, and operationalising change via 'Marmot Accelerator' programmes on the ground.

Achieving meaningful improvements in outcomes on health and its determinants, such as employment and education, requires a multifaceted approach. This will include the use of data and evidence to inform prioritisation, the development of appropriate interventions, long-term investment and a shared commitment to collaborations for equity across stakeholders in Kent.

This report contributes to ongoing efforts to reduce inequalities and strengthen opportunities for skills building and good quality employment across Kent. It outlines the priorities and structures of the Marmot programme in Kent, collates and analyses data on a range of measures, including Kent's demography, health outcomes, and on a range of social determinants of health, including employment, economic inactivity, education, and housing. As part of the Marmot programme in Kent, the IHE, in collaboration with Kent Public Health Observatory (KPHO), have been developing a coastal indicator set to analyse the differences between outcomes of coastal and inland districts in Kent. This report begins to explore where these inequalities lie, with more detailed data analysis to come on a wider range of social determinant of health indicators, which are disaggregated by coastal and inland Kent and by socioeconomic position and age.

The high-level data on health inequalities in Kent shows that the county performs better than England on several critical measures, including life expectancy, preventable mortality, and overall level of deprivation. However, these county-wide averages mask significant variation within Kent itself, including stark inequalities between coastal and inland districts. Similarly, data on the social determinants of health shows marked inequalities within districts by socioeconomic position and area deprivation across Kent, even in the wealthiest areas. Coastal districts, particularly Thanet, consistently experience higher rates of child poverty, economic inactivity, and financial insecurity than inland areas.

To build upon the positive work happening in Kent, the IHE provide a range of high-level recommendations for the Kent system to improve health equity outcomes. These focus on inequalities in educational attainment, getting people into good work, improving financial security, and increasing the provision of safe and secure housing. Alongside these focus areas, we recommend embedding health equity across the Kent system and involving a range of sectors and organisations. This includes equitable allocation of resources, setting of a long-term ambition, and alignment with and improvement of the interventions which already exist. Partners for greater health equity in Kent include businesses, public services, voluntary, community, faith and social enterprise (VCFSE) organisations, and the County and District councils.

The recommendations are intentionally high-level at this stage and trigger the start of a stakeholder consultation process. The consultation will lead to refinements of the proposed recommendations and garner cross-system ownership and responsibility. These more detailed, co-produced recommendations will be published in an action plan later in 2026.

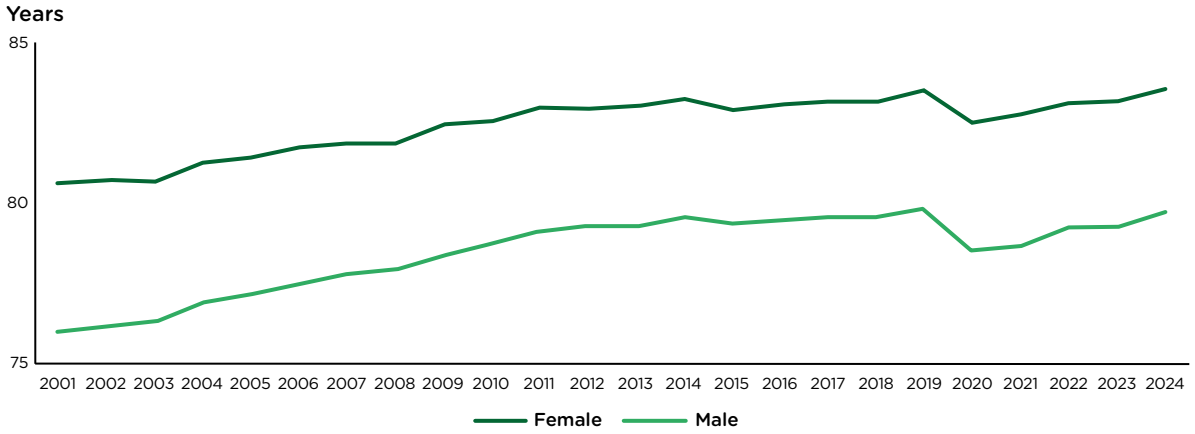
CHAPTER 1
INTRODUCTION

1A. HEALTH AND HEALTH INEQUALITIES IN ENGLAND

Across England, improvements in population health are stalling and by some measures, deteriorating. Moreover, unjust health inequalities between the most and least deprived groups of the population are widening.

This is most starkly illustrated through analysis of recent trends in life expectancy. Figure 1 shows that improvements in life expectancy have stalled since around 2010. This coincides with the introduction of austerity policies, which led to cuts in public and local government services, public health funding, education, and welfare support, all of which are evidenced to be protective of good health [1]. The sudden drop in 2020 is related to the Covid-19 pandemic.

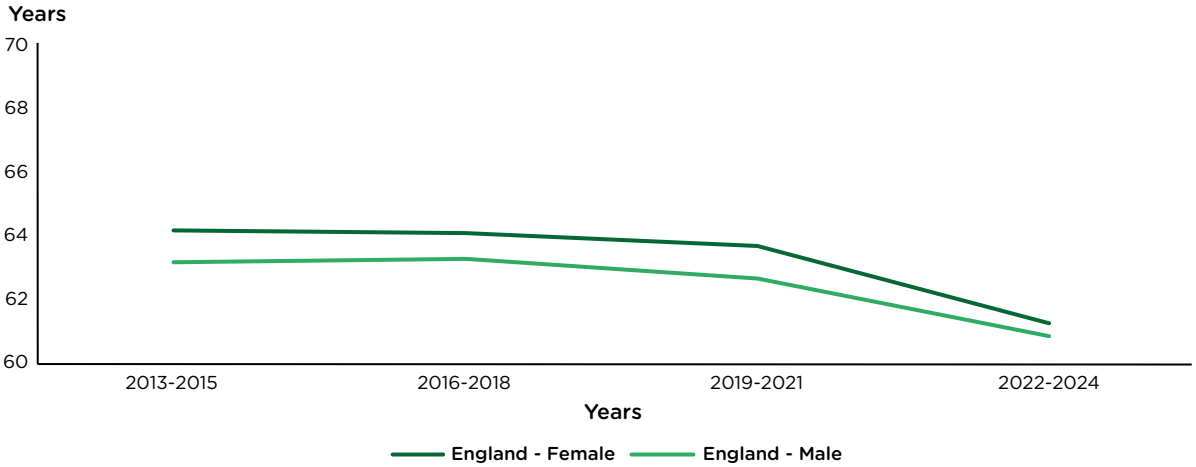
Figure 1. Life expectancy at birth, by sex, England, 2001 to 2024



Source: *Fingertips, Office for Health Improvement and Disparities (OHID), 2026*

The average number of years someone can expect to live in good health – their healthy life expectancy – is shown for England in Figure 2. While the pandemic has worsened the pace of this decline, healthy life expectancy was already stalling before 2020 and has continued to decline post pandemic, particularly for women.

Figure 2. Healthy life expectancy, by sex, England, 2013-15 to 2022-2024

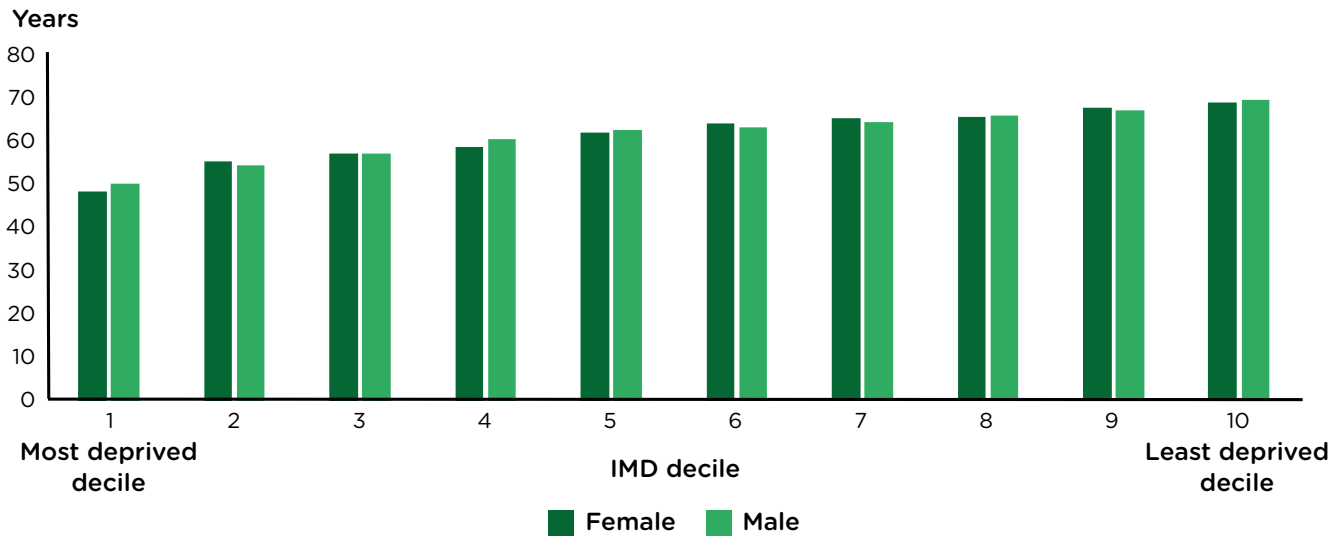


Source: *Fingertips, OHID, 2026*

There are wide inequalities in life expectancy and healthy life expectancy with people living in the least deprived areas of England enjoying much better health and longer lives than those living with lower incomes and in deprived areas. These inequalities in health outcomes are closely related to socioeconomic position and area deprivation, resulting in a 'social gradient'. This means the greater the level of deprivation of an area of residence, the worse health is (see Figure 3). In turn, the most deprived decile of the population is more likely to live shorter lives, longer of which is spent in ill health, than those in the least deprived decile.

The evidence of a clear and predictable social gradient in health shows that this is not simply the result of individuals making decisions which harm their health. These inequalities are unjust, and preventable with the right approach (see 1C Driving progress towards health equity): action to reduce inequalities in the social determinants is needed to support opportunities to live healthier and longer lives, right across the social gradient. This includes adopting proportionate universalism: evidence-based interventions delivered at a universal scale, but proportionate to the level of need. This approach is necessary to flatten the gradient in health.

Figure 3. Healthy life expectancy by sex and deprivation decile, England, 2022-2024



Source: *Fingertips, OHID, and Office for National Statistics (ONS), 2026*

1B. POLICY CONTEXT

Despite these steady declines in population health and widening inequalities in health, there is no overarching national strategy dedicated to tackling health inequalities. There are, however, national policies and interventions that provide opportunities to improve health equity and to act on the social determinants of health.

These include Get Britain Working [2] and the Industrial Strategy [3] for economic policy; Fit for the Future: 10 Year Health Plan [4] (particularly the commitment to a Neighbourhood Health Service) for healthcare policy; Pride in Place [5] programme for neighbourhood development; and Best Start in Life [6] and Youth Strategies [7] for childhood.

Given the focus on coastal communities in the Kent Marmot programme (see more in 1D Kent as a Marmot Place), it is also relevant to note that, while there have previously been policies dedicated to regenerating coastal communities – such as the Coastal Communities Fund and Coastal Community Teams [8] – these are not currently active. Nationally, many coastal areas have suffered long-term historical decline and lack of investment, and coastal communities often have particular disadvantage and poor health as a result (although this does not apply to all of them).

The annual Chief Medical Officer's (CMO) report in 2021 specifically focused on Health in Coastal Communities, stating that 'coastal communities have been long been overlooked with limited research on their health and wellbeing' [9]. Since, an increasing body of research has sought to rectify this, finding worse health outcomes for adults who spent their adolescence in deprived coastal communities [10]. The main recommendation of the CMO's report was a national strategy to improve the health of coastal communities [9]. Despite this, action has been limited. However, the report also calls for local action, which emphasises the importance of the Kent Marmot Coastal Region programme. Collective action with local stakeholders on policies impacting the social determinants of health is essential in understanding and meeting the needs of the Kent coastal population and in reducing health inequalities across Kent.

1C. MARMOT PLACE APPROACH

THE SOCIAL DETERMINANTS OF HEALTH

In contrast to the common misconception that the NHS has the most influence on health outcomes, health is mostly shaped by factors outside the healthcare system including where people live, grow, work and play known as the 'social determinants of health'. Although much of this is driven by national policy, there is scope and opportunities at local level to act on the social determinants, mitigate harms and improve health and reduce inequalities in health.

THE MARMOT APPROACH

The UCL IHE was established by Professor Sir Michael Marmot to support greater health equity in England and around the world and is based on evidence showing that action in 8 key policy principles is effective for improving health and reducing inequalities. These are known as the Marmot 8 Principles, developed in the 2010 [1] and 2020 [11] Marmot Reviews. These have been adopted by the more than 60 places across the UK and globally that IHE have collaborated with, now all 'Marmot Places'.

The principles are:

1. Give every child the best start in life
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 a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention
7. Tackle racism, discrimination and their outcomes
8. Pursue environmental sustainability and health equity together

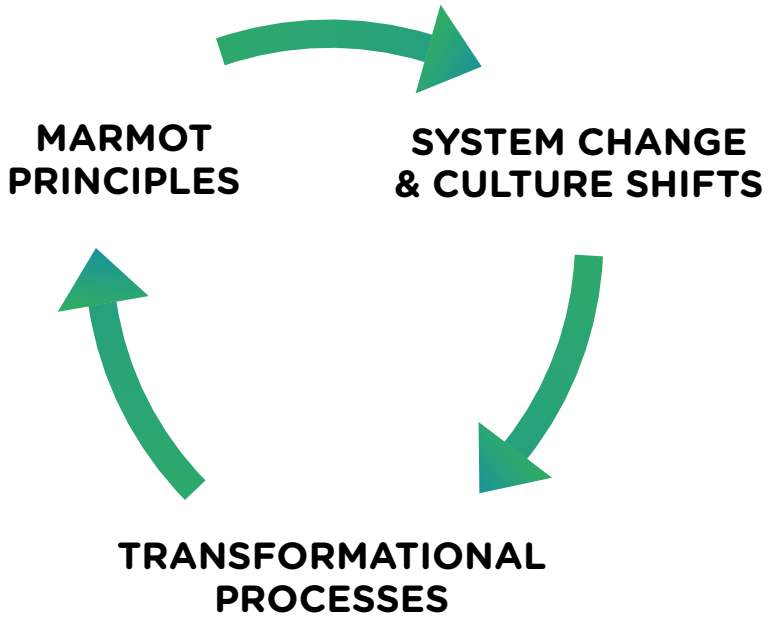
Part of work in a Marmot Place involves collation of evidence and analysis across a range of metrics relevant to health and the social determinants of health, according to these 8 principles. This report provides a summary of those measures, serving as a valuable exercise for identifying where Kent has scope to improve action on health inequalities.

Beyond this, there are other common elements of the approaches taken in each Marmot Place:

- Recognition that health and health inequities are mostly shaped by the social determinants of health
- Assessment of local inequalities in health and the social determinants of health
- Identification of actions that are already happening, gaps in existing approaches and development and delivery of steps to go further to reduce inequalities
- Evaluation of efforts and how partners can work together more effectively
- Strengthening the health equity system and collaborating with the national system

Impacts from the approach are summarised into three main areas, visualised in Figure 4 and explained below:

Figure 4. The Marmot approach: securing change to reduce inequalities in the social determinants of health



ACTION ON THE MARMOT 8 PRINCIPLES

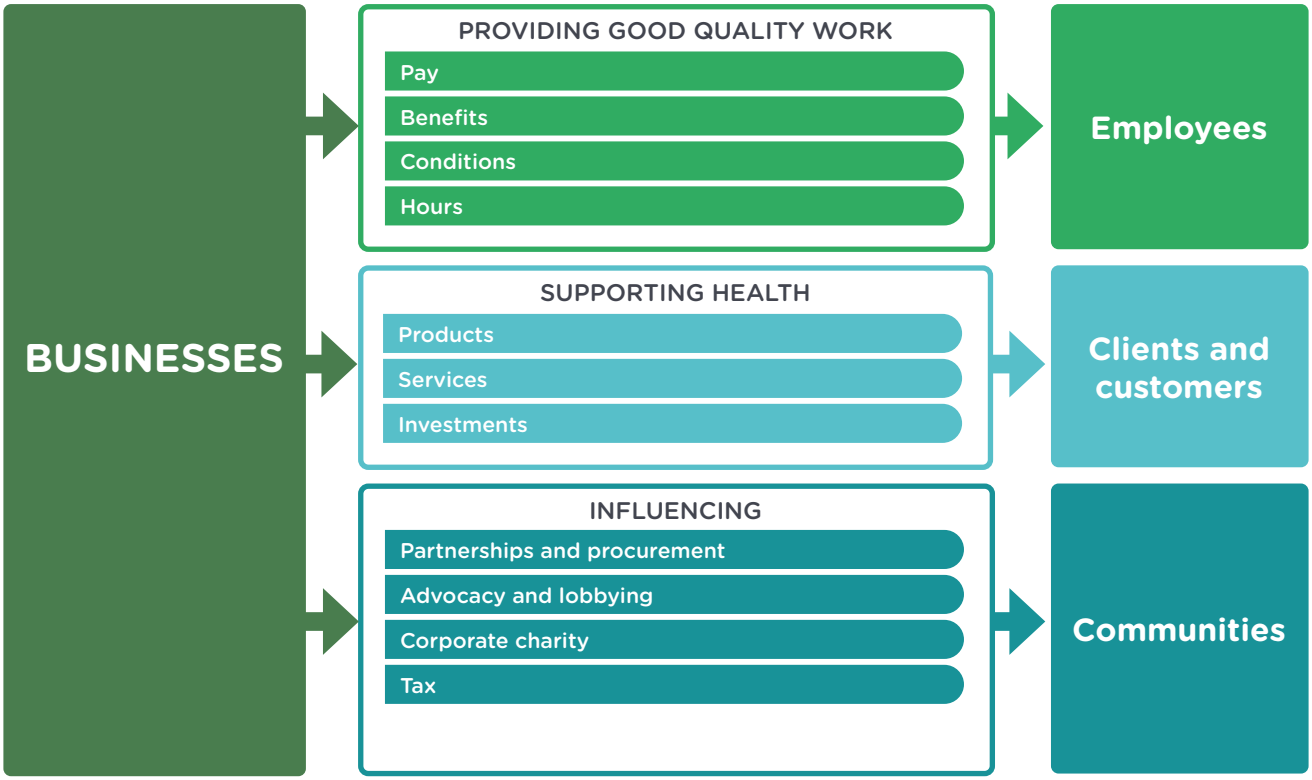
As highlighted above, each place identifies priority areas within the Marmot 8 principles as an entry point to action. The prioritisation process includes assessment of the data with IHE, discussions with local stakeholders, including residents and partners, and identification of opportunities in the local policy and strategic context. Places usually select 2-3 priority areas during the 2-year programme.

SYSTEM CHANGE AND CULTURE SHIFTS

System change and culture shifts refers to changes within and between organisations which allow for health equity to be embedded. These include governance for health equity, strong and dispersed leadership and advocacy for health equity, greater capacity in the commissioning, design and delivery of services to embed action for health equity, adoption of health equity in all policy, and stronger partnerships and collaborations between a range of sectors including local government, VCFSE organisations, public services and healthcare, and businesses.

The role of businesses is particularly important to consider in Kent, given the programme's focus on employment and skills for work. Figure 5 summarises three main ways through which businesses shape health: by providing good quality work, supporting the health of their clients and customers, and driving healthier communities through their influencing power, ability to act as an anchor organisation, and their direct and indirect financial contributions [12]. Not only is this the 'right' thing to do, but there are benefits for businesses too, such as through improved recruitment, retention, and employee health and wellbeing. Many businesses have made improvements in all of these areas, leading to better health and IHE will work with stakeholders across Kent to identify ways for businesses to strengthen their impacts and involvement in health equity.

Figure 5. How businesses shape health: the IHE framework

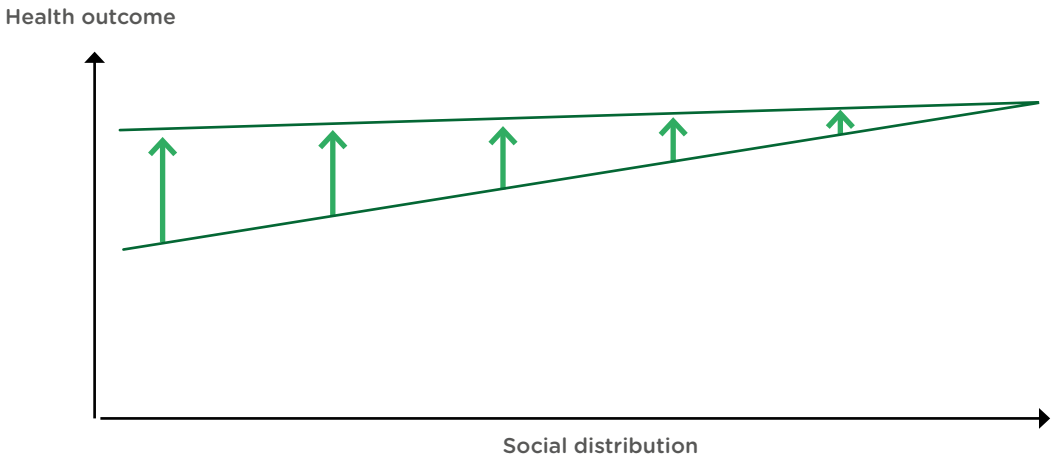


TRANSFORMATIONAL PROCESSES

Finally, transformational processes refer to how action for health equity can be operationalised. They include ensuring resource allocations are proportionate to the scale of need, equitable commissioning and embedding social value, expanded anchor organisation approaches, strengthened accountability for health equity within organisations and use of indicators and data to monitor progress on the social determinants of health. These are the levers which embed change locally.

Policies are often implemented in ways which do not attend to inequities or even exacerbate them. Policies which are universal tend not to reduce inequity, while those that are narrowly targeted do not flatten the gradient in health. IHE advocate for 'proportionate universalism' in the design and delivery of services and in resource allocations. This is a guiding principle that expresses the importance of the universal provision of support, goods and services that improve health while being designed to be proportionate to the scale of need. The aim of this is to raise overall levels of health as shown in Figure 6. An example of proportionate universalism in action, would be the provision of a housing service open to all residents but located in an area where there is greatest housing quality need due to deprivation.

Figure 6. Proportionate universalism



1D. KENT AS A MARMOT PLACE

In 2024, Kent commissioned the UCL IHE to support development to become a Marmot place and the first Marmot Coastal Region. Kent has over 350 miles of coastline and just under a quarter of the population living in coastal towns (23.5 percent in 2020) [13]. While many coastal areas are places of natural beauty, the decision to focus on these communities is in recognition of the poor health and high deprivation among many of Kent's coastal areas. This also aligns with the declared 2025/26 priority area of coastal regeneration announced by Kent County Council's political leader [14].

KENT'S PROGRAMME AND PRIORITY AREAS

The Kent Marmot Coastal Region is taking a proactive approach to health inequalities using the Marmot approach, which involves action across three tiers of impact. These recognise the requirement to take both a top-down and bottom-up approach to system change to be embedded and sustained. These three tiers are defined as:

Tier 1: Top-level change through addressing long-term coastal inequalities

Tier 2: Middle-level change through aligning systems for work and skills initiatives, the chosen priority theme areas for the first phase of the programme

Tier 3: Ground-level influence by conducting small-scale impact testing via 'Marmot accelerators'

The first tier of top-level change seeks to embed a systemic shift across Kent that develops a coastal equity lens which guides the delivery of appropriate support and services. Currently this systemic approach is being developed in governance structures including the Marmot Coastal Advisory Board and Steering Group, as described below. Moreover, the IHE and Kent Public Health Observatory (KPHO) are collaborating to build a dataset that analyses inequalities in Kent. Specifically, this work is focused on developing a indicator set, setting out health inequalities and inequalities in the social determinants of health in Kent, focussing on coastal regions. This will be a tool to understand and track progress, sustain effort of the Marmot programme, and develop programmes and support accordingly. The initial data analysed through this workstream is explored throughout Chapter 2 and Chapter 3 and a more comprehensive data pack will be published later in 2026.

System alignment is the ambition for the second tier of developing approaches for health equity. To begin with, this focuses on employment and skills which have emerged as priority areas for the Kent Marmot Coastal Region programme, due to relatively high unemployment and economic inactivity in coastal communities, particularly among young people. A key priority is to align with existing interventions on work and skills across Kent. Stakeholders will need to collaborate to guarantee that commitment to health equity is a shared ambition and embedded across programmes. Supporting and connecting with other programmes and strategies will lead to better alignment, streamlined use of resources, reduced duplication, and improved awareness among residents about the services available to them. Complementary programmes on work and skills for work across Kent include (but are not limited to):

- Get Kent and Medway Working Plan [15]
- Local Skills Improvement Plan [16]
- Kent and Medway Economic Partnership [17]

In addition, the IHE have been involved with multi-stakeholder meetings to support progress on embedding health equity in existing approaches. For example, the IHE participate in the quarterly Swale Skills and Employment group which is attended by the Council, the local Health and Care Partnerships (HCPs), the VCFSE sector, the Department for Work and Pensions (DWP) and other local bodies. This is one of numerous opportunities for the IHE take the role of a 'critical friend': to challenge, hold to account, support and collaborate with cross-sector partners and bring expertise, including from other Marmot places across the country.

'Marmot accelerators' comprise the third tier of the Kent Marmot coastal approach. These are a developing set of innovation initiatives that are supported by local seed funding, and aim to bring people into work. This is part of the test-and-learn approach being adopted in Kent; these initiatives will build a local evidence base of best practice that can be expanded and replicated elsewhere in Kent. Accelerators are currently in development, with a likely focus on young people who are Not in Education, Employment or Training (NEET) and building career readiness among young people in the Isle of Sheppey. These accelerators are an opportunity for filling identified gaps in the provision of skills support and training and improve existing initiatives to better meet the needs of the population.

Aligned with this ground-level approach, the IHE have identified additional opportunities to focus support in Kent including engaging with Neighbourhood Health Teams, facilitated by the district level Health Alliances.

This is an exploratory piece to learn from existing best practice in Kent and embed a health equity and social determinants of health lens in Neighbourhood Health approaches and teams as they develop as leaders of community services and prevention-focused support going forward. Using IHE expertise on neighbourhood health implementation, this work presents opportunities to share and influence development of this programme nationally, as well as across Kent.

STRENGTHENED GOVERNANCE STRUCTURES FOR HEALTH EQUITY

At a senior level, Kent's Marmot Coastal Region programme is overseen by an Advisory Board chaired by Professor Sir Michael Marmot. This group will meet two to three times a year, and held its first meeting in February 2026. The Advisory Board provides advice and support for a system-wide, strategic approach to strengthening health equity and addressing inequalities in the social determinants of health across Kent's coastal communities. Board members will build effective and collaborative partnerships with key stakeholders and identify where knowledge and skills require development across the system. The group includes a variety of stakeholders from the IHE, Kent County Council (KCC), district and borough councils, the East Kent HCP and the DWP. The full membership of this group can be found in Annex A. An important challenge is to identify businesses who recognise their potential role in achieving greater health equity across Kent and develop the potential opportunities for contributions they can make through their recruitment and employment practices and by supporting and developing their local community, place-based impacts.

Meanwhile, a Steering Group meets every two months and reports into the Advisory Board. The purpose of this group is to support operationalising the approaches for improving health equity and the social determinants in coastal areas of Kent. The group facilitates strategic and place-based collaborative engagement and action by a range of partners. Membership of this group is wide and includes stakeholders from the IHE, and borough, district and county council representatives. While there are also VCFSE sector representatives, the group will expand its membership where appropriate to ensure adequate and diverse representation. The full membership of the Steering Group can be found in Annex B.

NEXT STEPS FOR THE KENT MARMOT COASTAL REGION

Looking ahead, momentum for the Kent Marmot Coastal Region will be fostered in collaboration with the IHE. Priorities for the programme include continuing to activate stakeholders across the governance groups, both those who are already present and expanding the reach to ensure an appropriate breadth and diversity of organisations are represented. Businesses who are 'thought leaders' in this space will be brought in to develop actions which support health equity as well as productivity and recruitment and retention. In addition, the coastal indicator set will be agreed by Steering Group and Advisory Board members, and plans and action for the monitoring tool already agreed.

Another key milestone is the Marmot Launch event in March 2026 where colleagues will come together in Dover to hear a keynote address from Professor Sir Michael Marmot, learn from local and national healthy equity initiatives, and workshop ideas for continued and expanded action in Kent.

Lastly, there are many opportunities for expansion of the programme in its next phase. This is possible through the identification of further Marmot accelerator programmes and strengthened engagement with aligned initiatives such as the Pride in Place community work. In time, the Kent Marmot Coastal Region will add to its focus on work, with an additional focus on good quality and affordable housing, in collaboration with the Kent Housing Group. Stakeholders and governance groups will explore such opportunities over the coming year of the programme.

While the future of KCC is uncertain amid local government reorganisation, the evidence, learnings and recommendations generated from the Kent Coastal Marmot Programme should continue to be driven by the whichever new body takes ownership of delivering council services across the county. This also reiterates the importance of responsibility being spread and embedded across the system and stakeholders, beyond local government, such as businesses.

DEFINING 'COASTAL' AREAS

One difficulty in exploring the challenges faced by coastal communities is that there is no generally accepted definition of what constitutes a coastal community [9]. While it could be defined simply by proximity to the sea, it could also be defined by more complex factors such as economic or cultural ties to the coast. The Ministry of Housing, Communities and Local Government take a broader definition. Namely, 'any settlement along the coastline or on an estuary, even including inland communities having a connection to the coastal economy' [18]. Adopting this more expansive definition of 'coastal' is an emerging area of research and consideration. As such, there remains limited analysis on why many English coastal towns experience worse health than inland communities [10].

This report analyses social determinants of health data by comparing a constructed Kent coastal area and inland area. While this report does not conclude whether these are challenges are exclusively experienced by populations living by the coast – in comparison to other areas which may experience similar issues with access, for example – it begins to identify differences in the social determinants of health between coastal and inland neighbours in Kent, including access to employment.

1E. PURPOSE OF THE REPORT AND RECOMMENDATIONS

This report provides an overview of health and the health inequalities in Kent, contextualising the county's performance on a range of key data indicators both with national averages, but also analysing differences *within* Kent. As mentioned above, for several indicators, analysis focuses on geographically specific areas and explores how certain measures differ between coastal and inland populations and places in Kent. The report concludes with a series of recommendations, framed around the Marmot principles, system change and culture shifts, and transformational processes.

For this report, these recommendations are purposely pitched at a high-level. This report is the beginning of stakeholder consultation process that will lead to the further evolution of these recommendations. Stakeholders across Kent will be encouraged to input local knowledge and craft elements of the detail required for actionable implementation, identify gaps and build ownership of an action and implementation plan. The outcome of this will be a short briefing with finalised recommendations and next steps later in 2026, and an action plan that has cross-system buy-in from the outset.

CHAPTER 2
LOCAL DATA SUMMARY

The next two chapters cover key indicators across health and the social determinants of health. Some indicators are directly related to the Marmot principles and are commonly analysed by the IHE. Additional indicators are selected to specifically draw out potential differences in health and the social determinants of health between coastal and inland populations in Kent.

This process of identifying these indicators took place through a working group consisting of KPHO and IHE colleagues which fed progress into the Steering Group. For these indicators, we have defined the coastal and the inland area at different geographical levels, adopting an iterative approach and allowing, when possible, to compare social determinants of health equity indicators with other dimensions of inequality.

These classifications need to be used with caution, as the approach adopted has limitations. However, they aim to enable the analysis of indicators at the lowest geographical level that is still statistically reliable. This report adds to existing assets of the KPHO, including rich evidence and data, by bringing in additional data and analysis on the social determinants of health.

The district level:

This district-level analysis offers a portrait of the demography in Kent, specific challenges facing Kent, and begins to highlight the differences in outcomes between inland and coastal communities in Kent at a macro-level. It does not, however, consider intra-district differences or the fact that some areas are not coastal.

For this workstream, the coastal area comprises the following districts: Ashford, Canterbury, Dover, Folkestone and Hythe, Swale and Thanet, and the inland areas include the districts of Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Malling, and Tunbridge Wells.

The Lower Layer Super Output Area (LSOA) level:

The Lower-layer Super Output Areas (LSOAs) include populations of between 1,000 and 3,000 residents. Those which have been defined as coastal by the IHE in this report fulfil at least one of the following criteria:

- they cover the Office for National Statistics (ONS) built-up areas (BUAs) which have a boundary within 1 kilometre (km) of the statistical coastline [19] and with a surface area of 50 percent or more within 3km of the statistical coastline [19] or
- they cover the ONS BUAs which have a perimeter of more than 2.5km within 25 metres of the statistical coastline or
- they have a coastline or are a 'very short distance' from the coast according to KPHO definition or
- they cover a population living on or near an estuary which have close characteristics to the population living in the coast and therefore have been added to the coastal geographical area.

By this set of criteria, of the 938 LSOAs in Kent, 567 have been classified as inland and 371 as coastal. The full list can be shared upon request.

The Middle-layer Super Output Area (MSOA) level:

The Middle-layer Super Output Areas (MSOAs) include populations of between 5,000 and 15,000 residents. Within this report, MSOAs are classified as coastal or inland based on the proportion of LSOAs within it that are inland or coastal. If the majority of LSOAs that constitute an MSOA are coastal, it is defined as coastal, and if the majority of LSOAs that constitute an MSOA are inland, the MSOA is classified as inland.

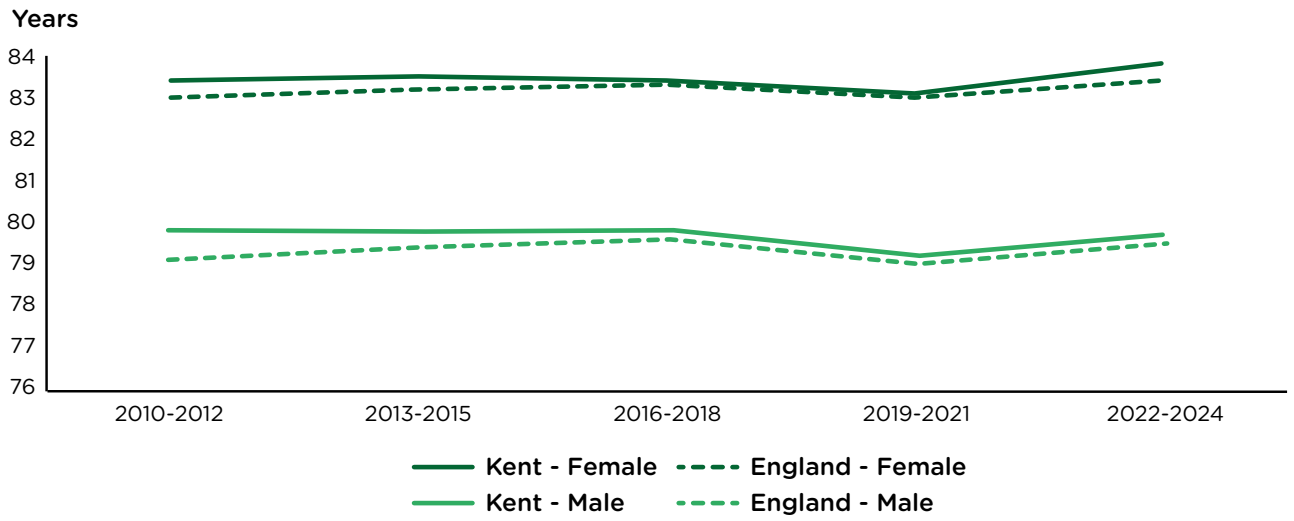
By these criteria, of the 183 MSOAs, 74 are classified as coastal and 107 as inland. The map can be found in Annex C.

2A. HEALTH INEQUALITIES IN KENT

This sub-chapter presents a range of health indicators at the Kent level and in Kent territories.

Figure 7 illustrates a deterioration in life expectancy since 2012-2014 at the national level, which can also be observed in Kent. Following 2010 and the policies of austerity, life expectancy stalled for females and declined for males in England and Kent. The overall trend in life expectancy in Kent follows that of England's but is slightly higher for both males and females.

Figure 7. Life expectancy at birth, by sex, Kent, and England, 2010-12 to 2022-24

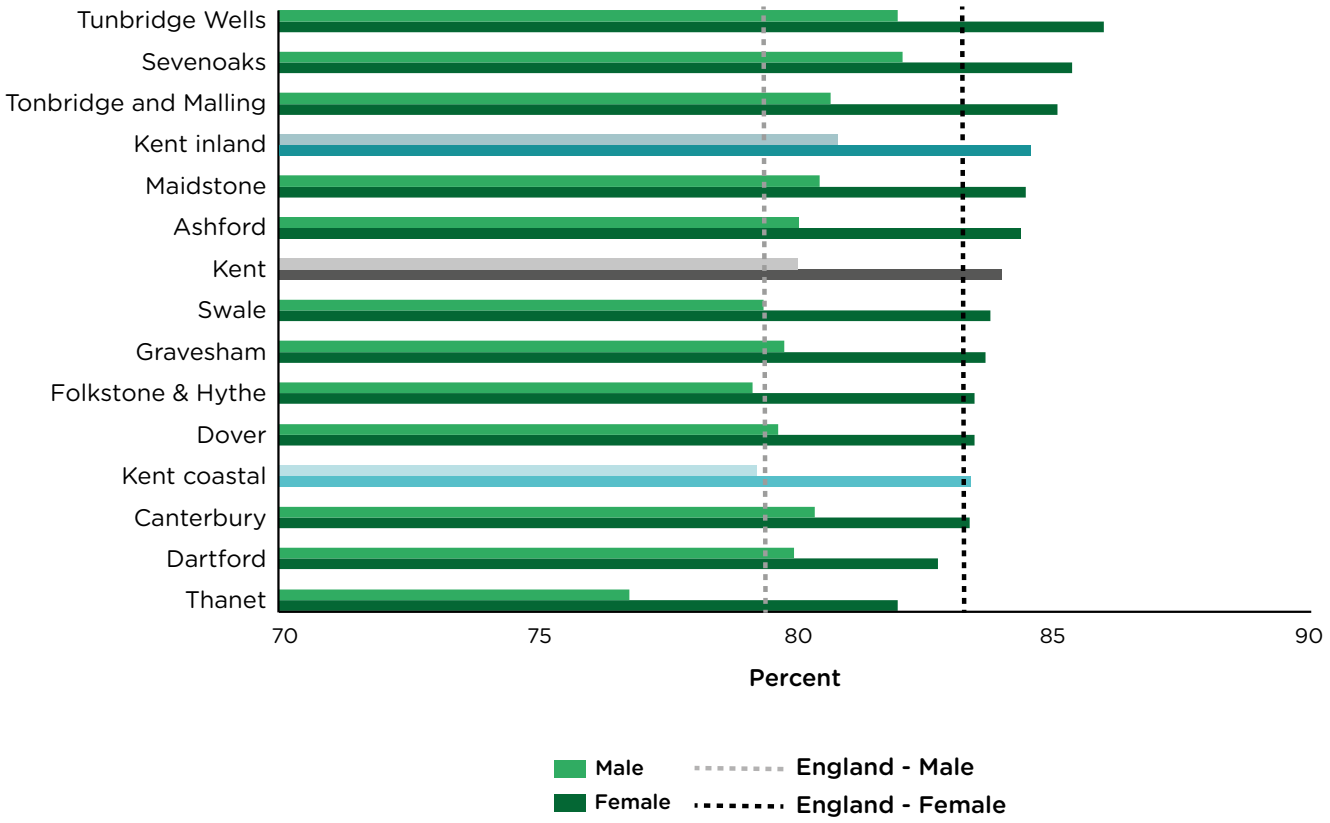


Source: *Fingertips, OHID, 2026*

Overall, life expectancy is slightly higher in Kent than in England. However, disaggregating the data by districts highlights variation between districts and the sexes which cannot be seen from the average for Kent, as shown in Figure 8. The life expectancy at birth in Kent shows a difference of 5.3 years to 2.4 years between males and females by district.

Most coastal districts have lower levels of life expectancy than average in Kent and in inland Kent districts. For men, life expectancy is 76.8 in Thanet, lower than in wider coastal Kent (79.3 years), Kent (80.1 years) and England averages (79.4 years), while female life expectancy is 82, also lower than the average in Kent (84 years), England (83.3 years) and Kent coastal regions (83.4 years). Thanet also has a larger difference between males' and females' life expectancy than in all other districts and in England. In contrast, in the inland district of Tunbridge Wells, the life expectancy is the highest of all Kent districts for females and males, at 86 years and 82 years respectively.

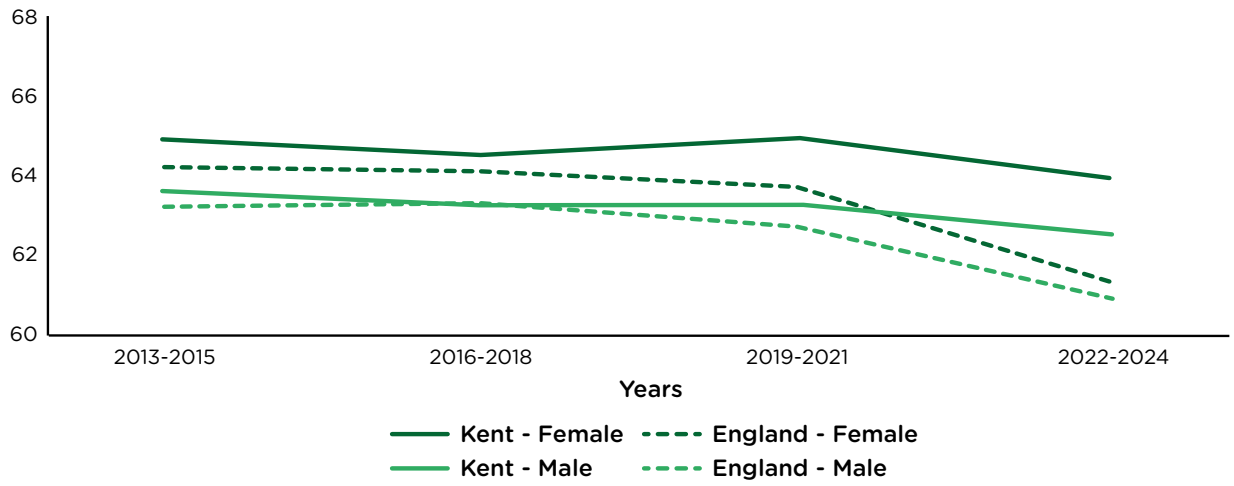
Figure 8. Life expectancy at birth, by sex, years, Kent districts, Kent coastal and inland districts, Kent, and England, 2024



Source: *Fingertips, OHID, 2026*

Figure 9 shows trends in healthy life expectancy in Kent and England – how long one can expect to live in good health. Before the pandemic, healthy life expectancy in Kent was higher than England for both females and males. Since 2018-2020, the trend has been clearly declining in Kent, but less steeply than in England. This data is not available for lower geographic areas.

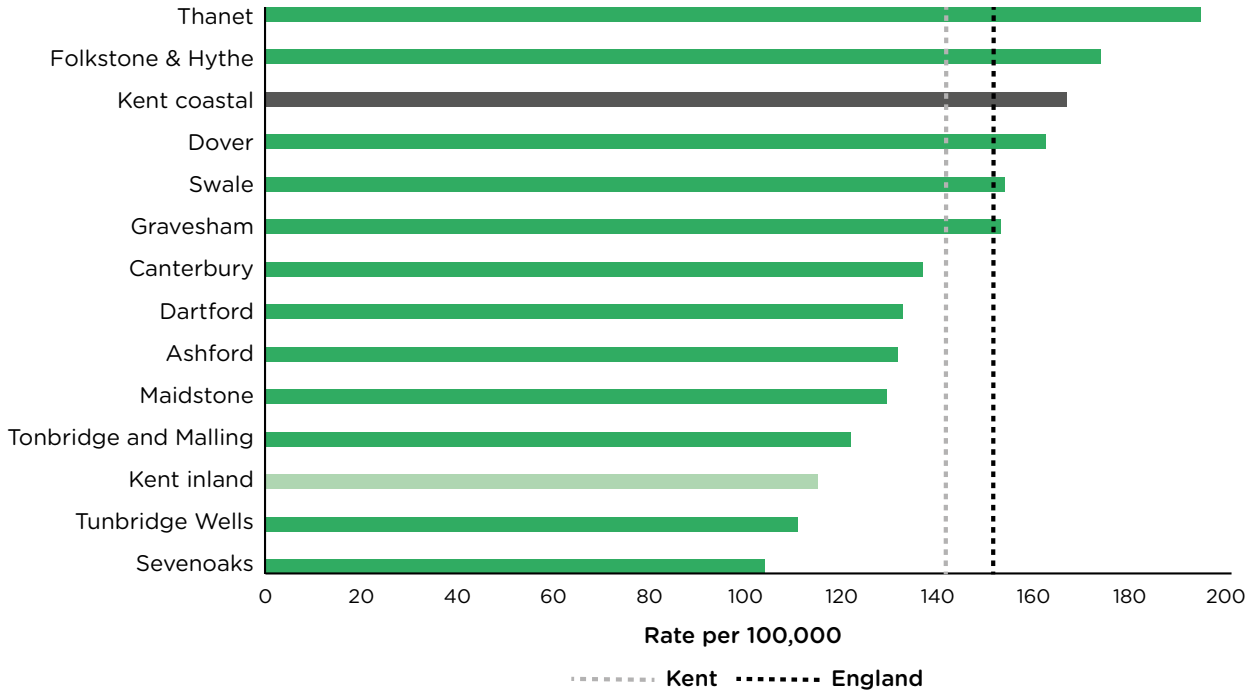
Figure 9. Healthy life expectancy, by sex, Kent and England, 2013-15 to 2022-24



Source: *ONS, 2026*

Preventable mortality is defined as 'causes of death that can be mainly avoided through effective public health and primary prevention interventions (that is, before the onset of diseases or injuries, to reduce incidence)' [20] and is measured by the mortality rate per 100,000 persons under 75-years-old. This measure is closely related to the social determinants: improving outcomes in the social determinants of health would reduce variation in rates of preventable mortality. Figure 10, shows that preventable mortality rate is lower in Kent than in England. However, rates of preventable mortality are much higher in Kent's coastal (166 deaths per 100,000) than inland (115 deaths per 100,000) districts.

Figure 10. Mortality rate from causes considered preventable, aged under 75, per 100,000, Kent districts, Kent inland and coastal, England, 2022 to 2024



Source: *Fingertips, OHID, 2026*

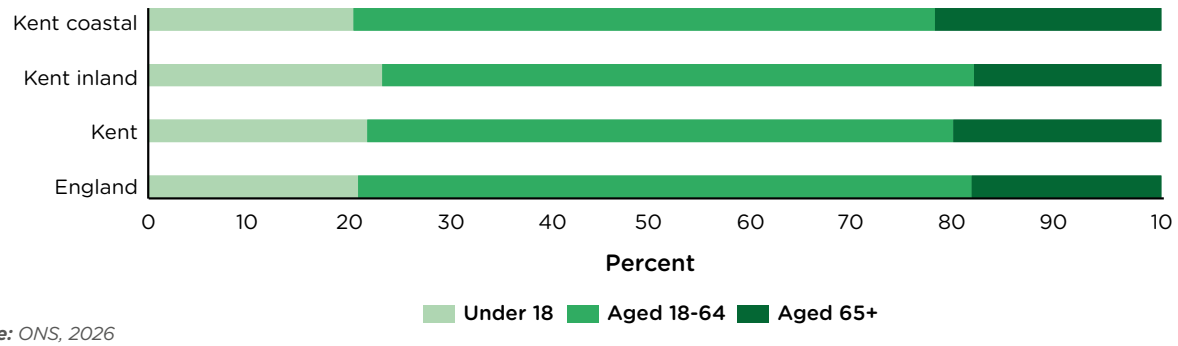
2B. DEMOGRAPHIC CHARACTERISTICS OF KENT

The size, age, and ethnicity of the population provide important context to understanding and tackling inequalities in health and the social determinants of health. Changes in these measures could result in inappropriate or misdirected services and support.

AGE

Figure 11 demonstrates that young people under 18-years-old make up a higher proportion of the population in Kent inland areas (23.1 percent) than in Kent overall (21.7 percent) and in England (20.8 percent). The percentage of older people in comparatively higher in the Kent coastal region, with people aged 65 and over accounting for 22.4 percent of residents, compared with Kent inland (18.5 percent), Kent (20.5 percent) and England (18.7 percent). Thus, Kent coastal area populations are older than England and inland Kent, and with a lower proportion of the population aged 19-64 and under 18.

Figure 11. Population estimates, by age categories, Kent districts, Kent coastal, inland, Kent and England, mid-2024

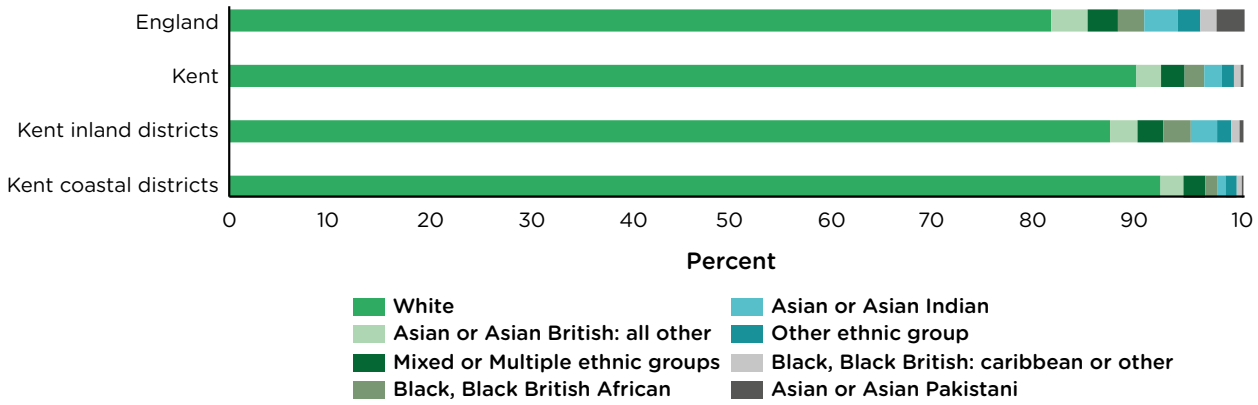


Source: *ONS, 2026*

ETHNICITY

Figure 12 shows the distribution of the population by ethnic groups shows a higher proportion of White residents in Kent (89.4 percent), particularly in the coastal districts (91.8), compared to England (81 percent). The percentage of residents from an Asian or Black ethnicity is much lower in Kent than in England, with some differences between coastal and inland regions. In Kent inland districts, the proportions of residents of Indian ethnicity are 2.6 percent and 2.7 percent for African. This is higher than in Kent coastal (0.6 percent and 1.2 percent respectively).

Figure 12. Ethnic group, percent, Kent coastal and inland districts, Kent and England, 2021



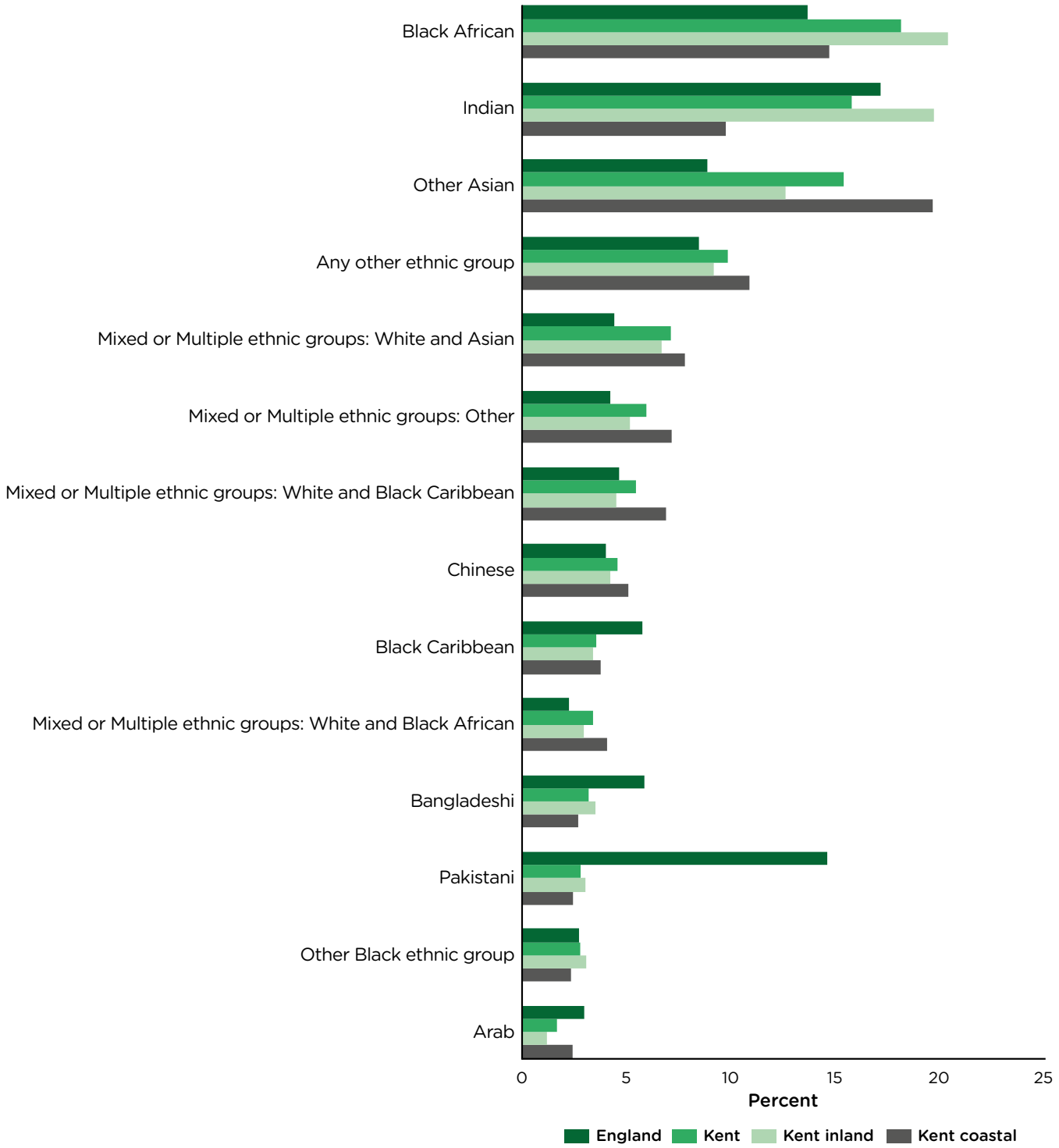
Source: *ONS, 2026*

Figure 13 shows the percent of Black, Asian, Mixed, and other ethnic groups in Kent, as categorised by the Census in 2021. This is disaggregated for Kent inland and coastal districts, compared with Kent overall, and England.

Not including white groups, the main ethnic groups represented in Kent and Kent's inland population are Black African (respectively 18.2 percent and 20.5 percent) and Indian (15.8 percent and 19.8 percent), and those are more represented than in England.

Other Asian population groups (other than Indian, Pakistani and Bangladeshi) are more represented in Kent coastal districts (19.7 percent) than in Kent (15.4 percent).

Figure 13: Asian, Black, Mixed and Other ethnic group, percent, Kent coastal and inland districts, Kent and England, 2021

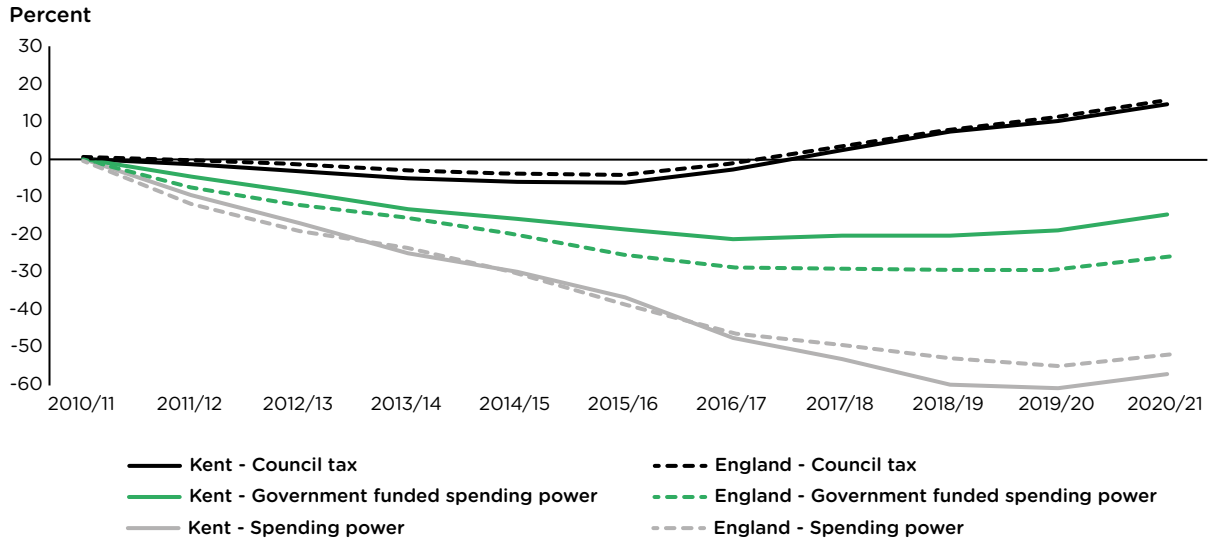


Source: *Census, ONS, 2026*

CHANGES IN LOCAL GOVERNMENT FUNDING

It is important to consider the changing financial context. There have been reductions in spending on public services across England since 2010 and related rapidly increasing need and widening inequalities. Figure 14 shows the decrease in spending power in Kent compared to England between 2010/11 and 2020/21. Spending power is a 'measure of the funding available from government grants, council tax and locally retained business rates'. It is measured in real terms, taking into account the inflation variations [21]. It suggests that the decrease in spending power was less notable in Kent than in England. The central government funding reduction in Kent is comparable to England and decreased by 51 percent between 2010 and 2021. Since 2015/2016, the increase in the council tax spending has been similar in Kent and in England.

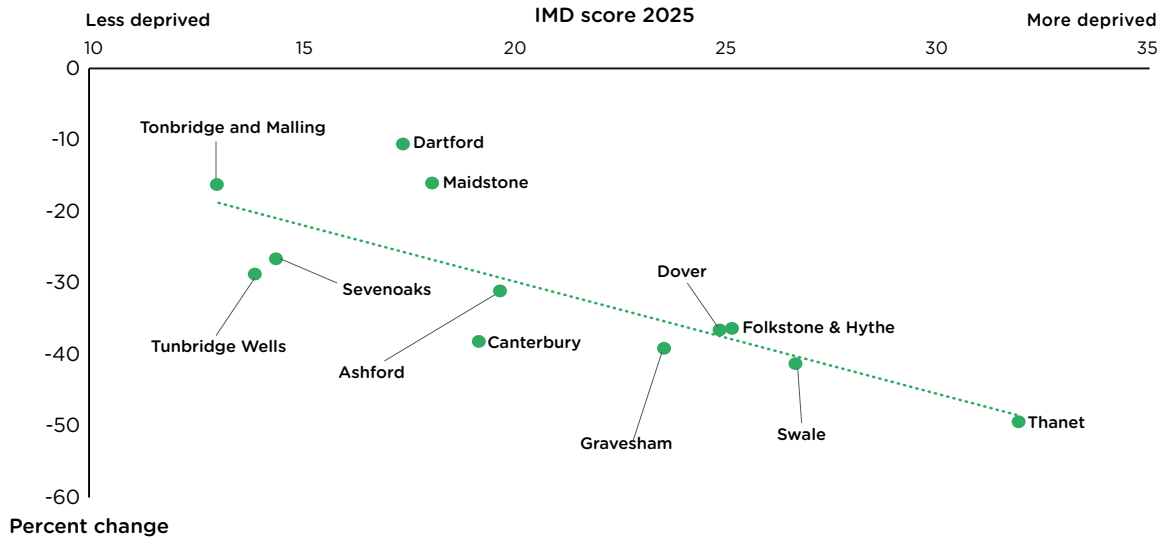
Figure 14. Spending power and its components indexed to 2010/11, percent, Kent and England, 2010/11 to 2020/21



Source: *National Audit Office, 2026*

The change in spending power per-capita, compared with districts' Index of Multiple Deprivation (IMD) scores, shows that populations living in more deprived districts have generally experienced a greater decrease in local authority spending power (Thanet and Swale). Conversely, in less deprived districts, the reduction in spending power has been smaller (Tonbridge and Malling and Dartford), as illustrated by Figure 15.

Figure 15. Change in spending power per capita and Index of Multiple Deprivation (IMD) 2025, Kent districts, between 2010/11 and 2020/21



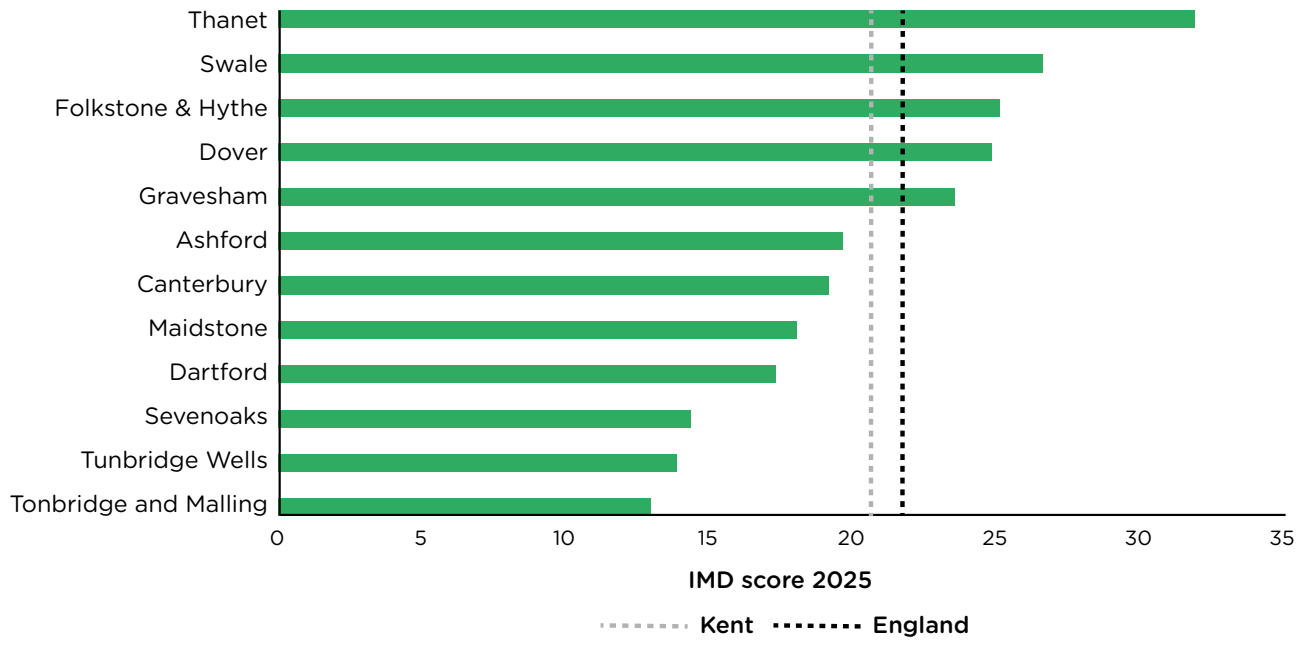
Source: *National Audit Office, ONS, 2026*

DEPRIVATION

The English IMD estimates the population's deprivation by combining seven dimensions: income, employment, education, health, crime, barriers to housing and services and living environment. [22]

Figure 16 shows that Kent's population overall is less deprived than in England, with an IMD score of 20.7, compared to the national average of 21.8. However, Kent's districts show substantial heterogeneity in levels of deprivation, with the IMD scores by district in 2025 ranging from 32 in the most deprived area (Thanet) to 13 in the least deprived district (Tonbridge and Malling). This gives particular emphasis to the concept of embedding proportionate universalism into service design and delivery across Kent, with more deprived areas requiring considerably more support and appropriately designed services. However, it is important to note that support remains necessary even in the least deprived areas, where there are still many households experiencing deprivation.

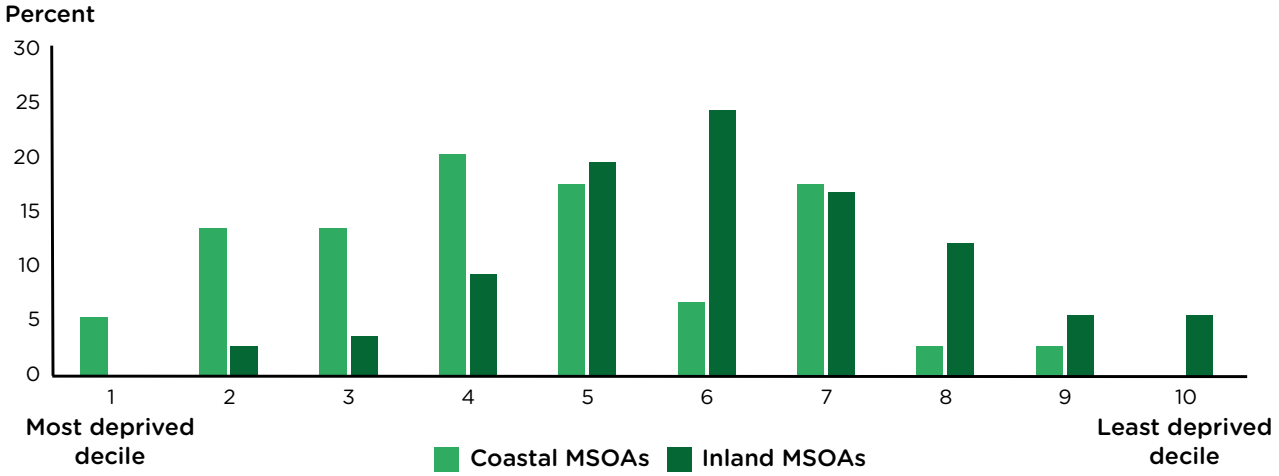
Figure 16. IMD, Kent districts, Kent, and England, 2025



Source: *OHID, Ministring of Housing, Communities and Local Government (MHCLG), 2026*

In this context of wide differences in levels of deprivation by districts across Kent, it is necessary to explore deprivation at the MSOA level – that is, deprivation within districts – and compare between the coastal and inland MSOAs in Kent. Figure 17 highlights deprivation within MSOAs at each IMD decile and compares the proportion of inland and coastal MSOAs represented in each one. There are 107 inland MSOAs and 74 coastal MSOAs in Kent. Overall, there is a higher proportion of coastal MSOAs concentrated in the lower deciles and a higher proportion of inland MSOAs in higher deciles. This demonstrates that, in Kent, the population living in coastal areas are more likely to be in a deprived neighbourhood than those living in inland areas.

Figure 17. Coastal and inland Middle-layer Super Output Areas (MSOAs), percent, by IMD decile, 2025

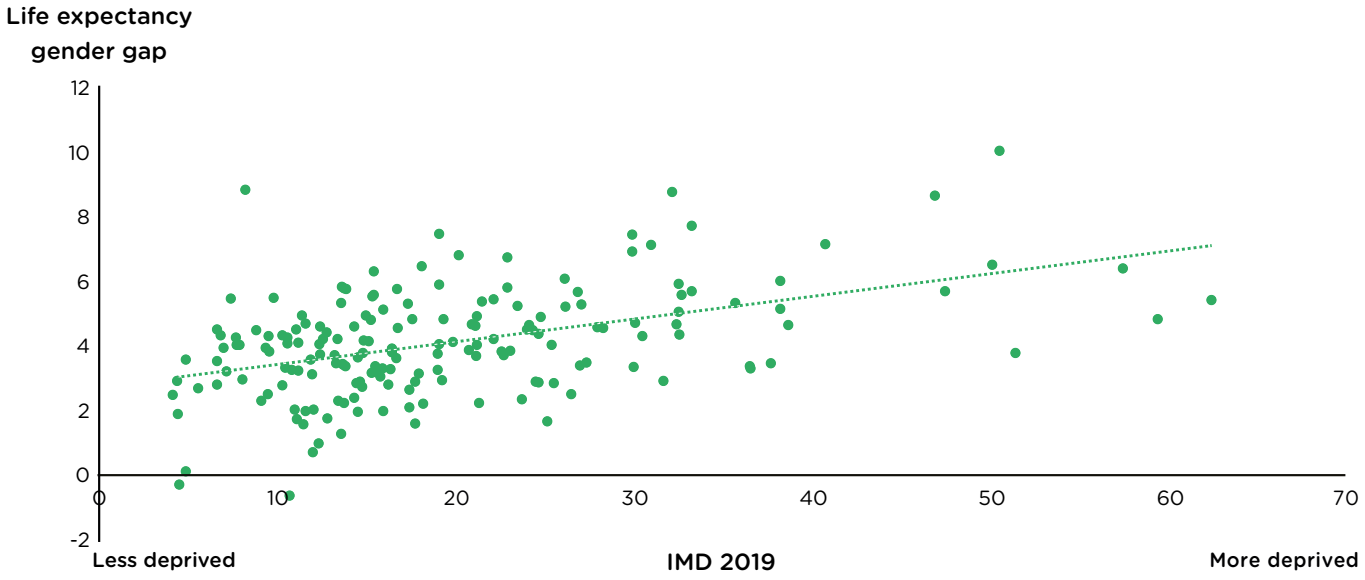


Source: *OHID, MHCLG, 2026*

Note: *two additional 'mixed' MSOAs (considered as both inland and coastal) both on the 5th quintile, but not represented in this chart.*

As observed nationally, life expectancy at birth by MSOAs in Kent closely relates to the level of deprivation and follows a clear gradient. The higher the IMD score (that is, the greater the deprivation), the shorter the life expectancy at birth for males and females. Figure 18 shows that the life expectancy gap, measuring the difference in life expectancy between females and males, tends to be higher in more deprived areas than in less deprived areas. This chart highlights major health and social inequalities between small areas in Kent.

Figure 18. Life expectancy gender gap (female-male) and deprivation (IMD score 2019), Kent MSOAs, 2019-2023



Source: *ONS, MHCLG, 2026*

CHAPTER 3

AN OVERVIEW OF THE DATA ON THE SOCIAL DETERMINANTS OF HEALTH IN KENT

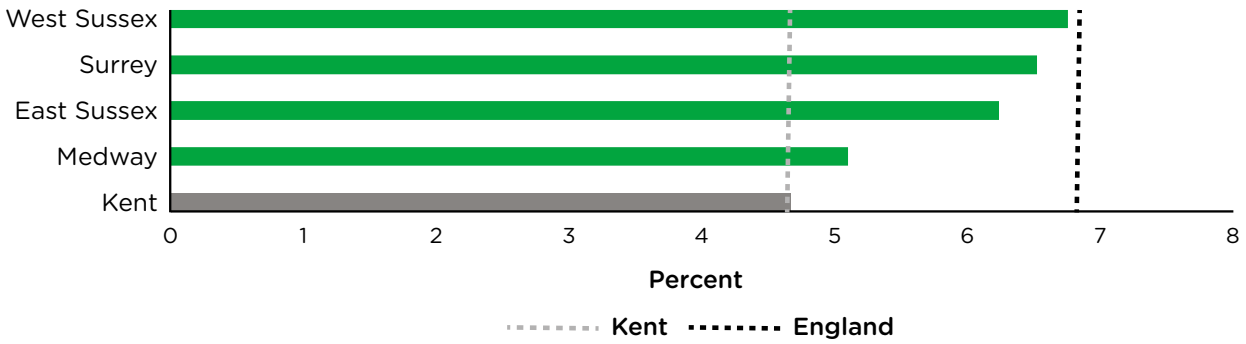
Inequalities in the social determinants drive health inequalities across the life course. This section outlines preliminary analysis of data relevant to several of the Marmot 8 principles in Kent, and for some measures, includes comparison between inland and coastal populations. Please note, analysis on how Kent is performing on a broader range of determinants will be published later in 2026.

3A. GIVE EVERY CHILD THE BEST START IN LIFE

The World Health Organisation defines low birth weight as less than 2,500 grams. It is an important measure as a low birth weight is associated with foetal and neonatal mortality and morbidity [23], as well as poorer long-term health and educational outcomes [1]. In addition, disadvantaged mothers are more likely to have babies of low birth weight, demonstrating how health inequalities can perpetuate across generations.

Figure 19 shows that the proportion of low birthweight of full term babies, in Kent (4.7 percent) is lower in Kent than the England average (6.8 percent) with a difference of two percentage points. Kent also has lower rates than its local neighbours and so is doing comparatively well by this measure.

Figure 19. Percentage of low birthweight of live babies*, Kent, geographical neighbours and England, 2018-2022



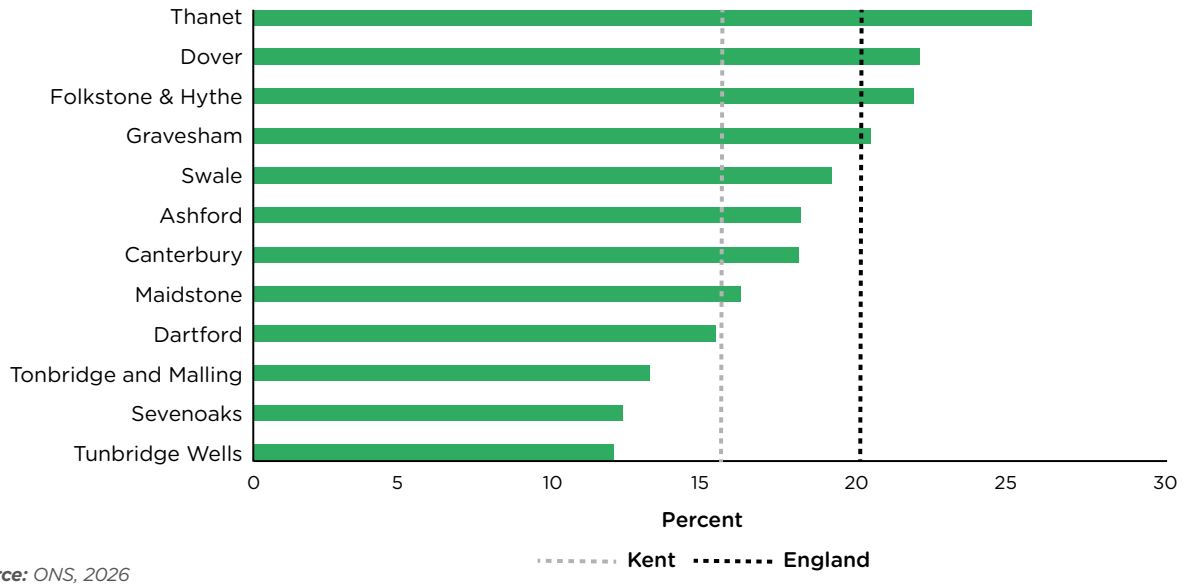
Source: *Fingertips, OHID, 2026*

** Low birthweight calculated as number of live births at term (>= 37 gestation weeks) with low birth weight (<2,500g) divided by the number of live births at term (>= 37 weeks) with recorded birth weight*

The first few years of a child's life are critical to their physical and mental development, as well as being a determinant for their future health. Experiencing poverty as a child can be harmful for future health outcomes and even perpetuate across generations. Children in low-income homes may also receive less attention at home from exhausted or preoccupied parents, which can lead to reduced cognitive development compared with their peers, before formal education even begins [24].

Across districts, the percentage of children living in a low-income family differs widely across Kent, ranging from 11.9 percent in Tunbridge Wells to 25.7 percent in Thanet (Figure 20). There is also a 5.8 percentage point difference between coastal and inland areas in Kent. While the average proportion of children living in relatively low-income families in Kent is lower than England, there are stark inequalities within Kent. Therefore, it is essential to understand child poverty at a lower geographical level, analysis which is planned in the next stages of the coastal indicators work.

Figure 20. Children in relative low-income families, percent, Kent districts, Kent, and England, 2022



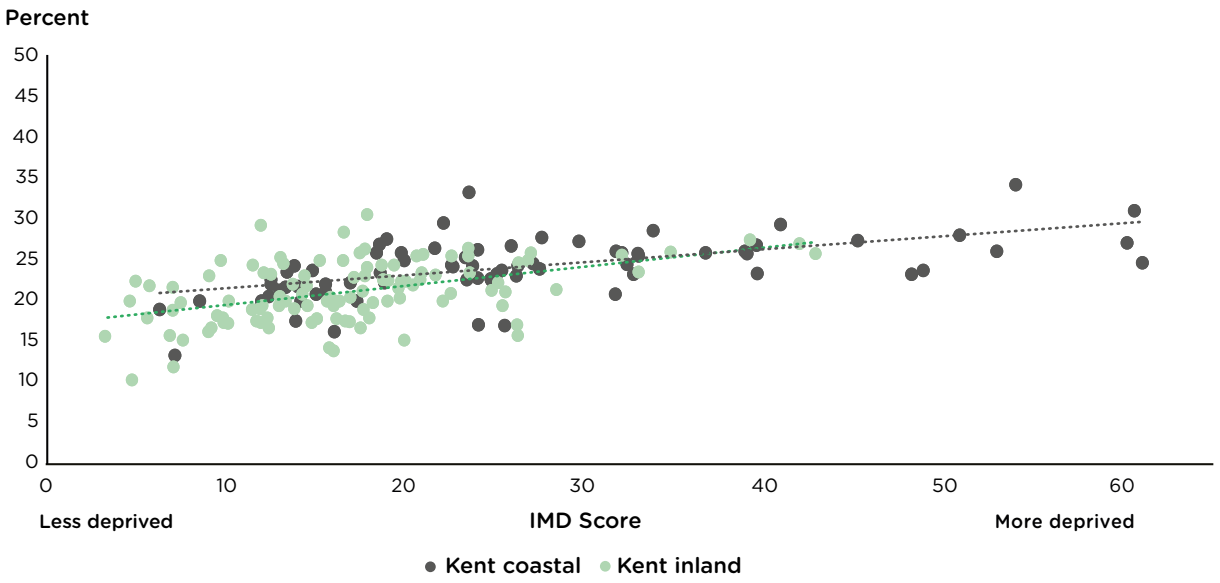
Source: *ONS, 2026*

Evidence shows that healthier foods are more than twice as expensive per calorie as less healthy foods [25]. To afford the Government-recommended, 'healthy' diet, the most deprived fifth of the country's population would need to spend 45 percent of their disposable income on food, and this rises to 70 percent for households with children [25]. Furthermore, proximity to fast-food outlets is associated with a higher risk of obesity [26]. of which there is a higher concentration in more deprived areas [27].

Those in the most deprived areas may also experience 'time poverty', with less time or ability to travel to source healthier food, due to working multiple jobs, having additional caring responsibilities or having to take forms of cheaper public transport that take longer. Living in poverty can also be a major barrier to children being able to exercise. This can include not being able to walk in a safe neighbourhood, or the family not having the resources to afford extracurricular activities such as sports clubs. These reasons are likely all contributors as to why overweight is more prevalent in more deprived areas.

Figure 21 shows the positive correlation between the prevalence of overweight children in reception and IMD scores in both coastal and inland MSOAs in Kent. There is a slightly higher prevalence of overweight children at reception age living in more deprived areas in coastal than inland areas in Kent, even in areas with similar levels of deprivation. This indicates a coastal effect.

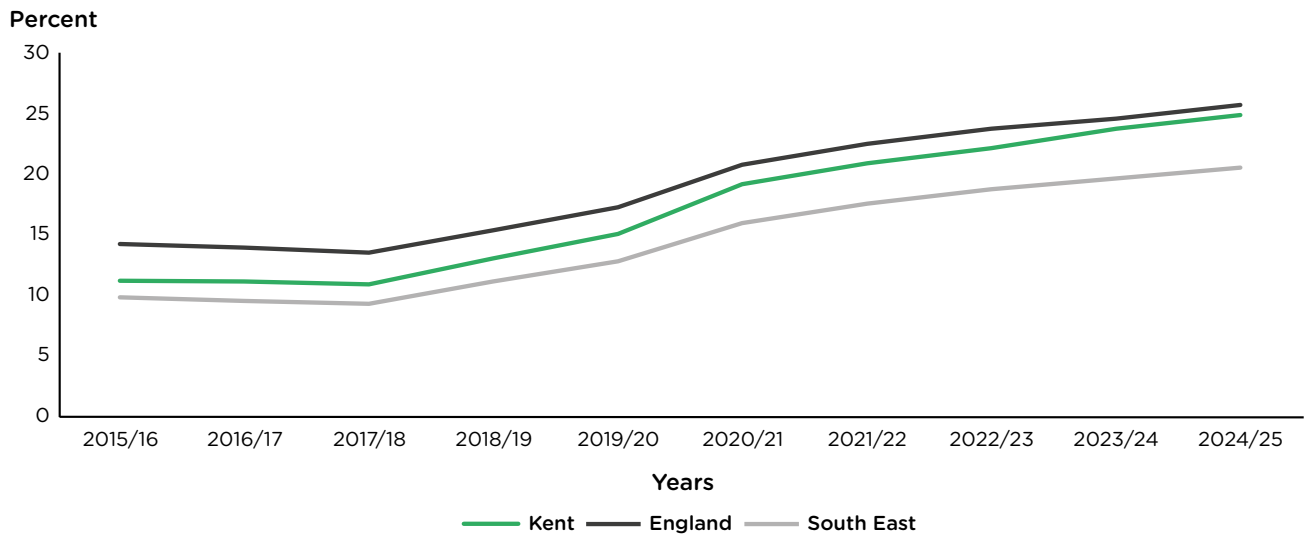
Figure 21. Reception prevalence of overweight and IMD 2025, Kent coastal and inland MSOAs, 2022/2023-2024/2025



Source: *National Child Measurement Programme, Department for Education (DfE) and MHCLG, 2026*

Figure 22 shows over a quarter of pupils in Kent are eligible for free school meals (FSM), a smaller proportion than in England, but higher than in South East. The gap between Kent and England is narrowing as the percentage of pupils eligible for FSM in England has increased faster than in Kent, since 2019.

Figure 22. Free School Meal (FSM) eligibility, percent, Kent, South East and England 2015/16 to 2024/25

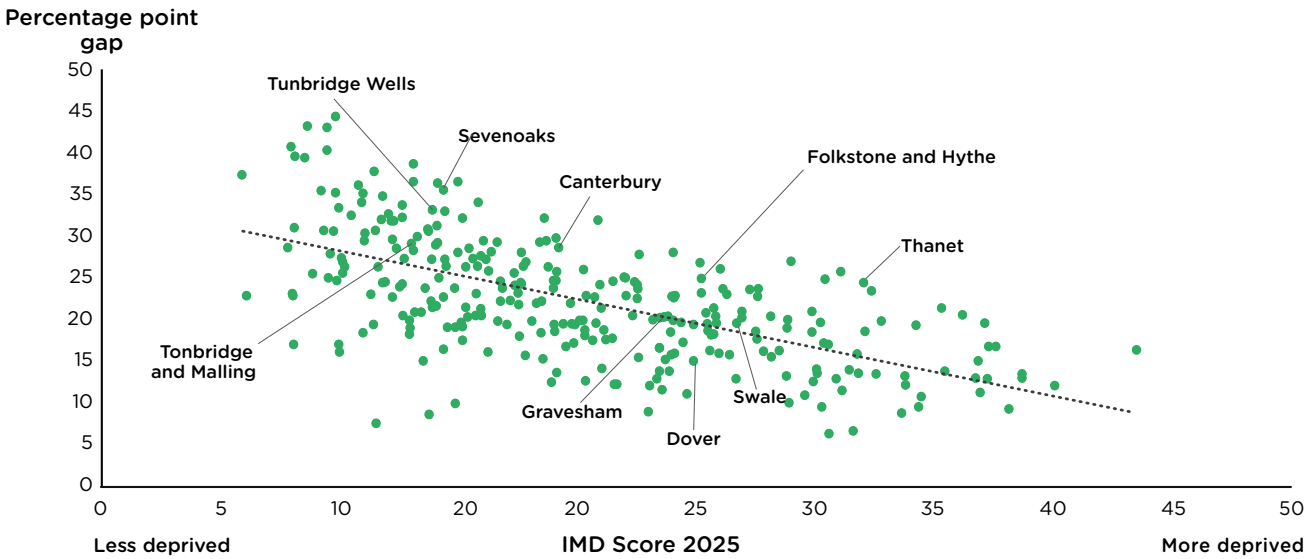


Source: *Department for Education*

Having a good level of development during the early years of life is an important indicator for future outcomes including health and other social determinants: not reaching the expected level of development at an early age can have knock-on effects on health and social outcomes throughout life [28].

Figure 23 presents the difference in levels of good development at the end of reception, between pupils eligible for FSM and pupils not eligible by IMD score, for all unitary and district councils in England. In the most affluent areas (those with the lowest IMD scores), the difference in levels of development is wider, than in more deprived unitary and district councils visualised on the left of the chart. In Kent, as in England, the least deprived districts have the widest gaps between pupils eligible and non-eligible for FSM.

Figure 23. Pupils achieving a good level of development at the end of reception, percentage gap between FSM eligible and non-eligible pupils and deprivation (IMD score 2025), English lower-tier local authorities, 2024/2025

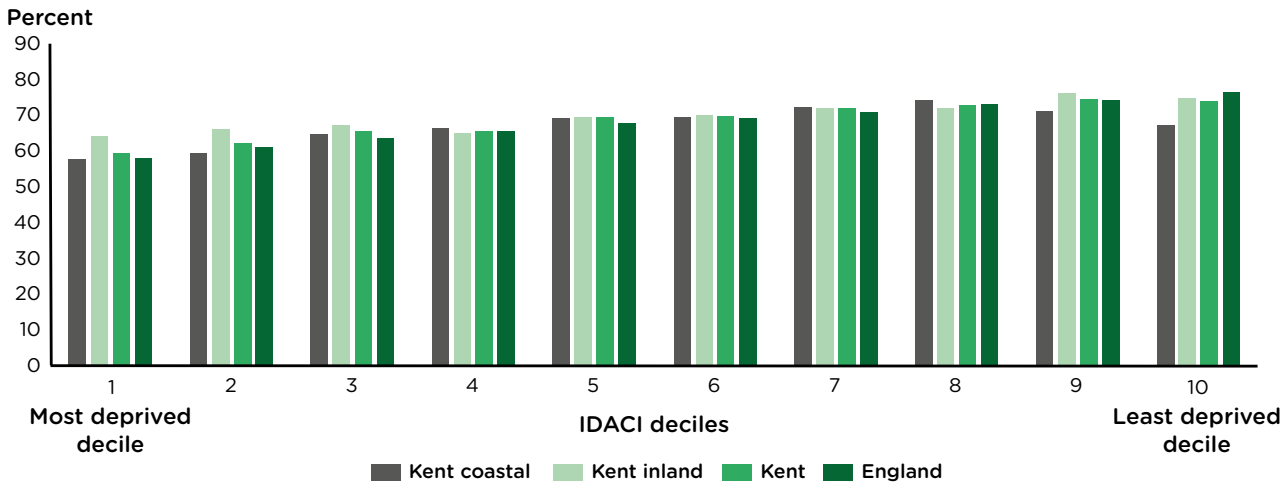


Source: *DfE and MHCLG, 2026*

Levels of development at the end of reception can also be related to income as well as area deprivation shown in Figure 24. This shows levels of development at the end of reception for Kent coastal and inland areas, and for Kent and England across the Income Deprivation Affecting Children Index (IDACI) deciles.

On average, Kent pupils have a slightly higher level of development at this stage than in England. However, among children living in more deprived deciles, levels of development are lower and particularly so in Kent coastal districts than in inland districts. This suggests that at a similar level of income, children living in coastal areas have a lower level of development than children living in inland Kent. In the fourth, fifth and seventh deciles, the differences between coastal and inland populations are smaller. Meanwhile, the eighth decile is the only one in which reception children living in coastal areas have a higher level of development than those who are inland.

Figure 24. Pupils achieving a good level of development at the end of reception, by Income Deprivation Affecting Children Index (IDACI) decile, Kent coastal and inland districts, Kent and England, 2022/23



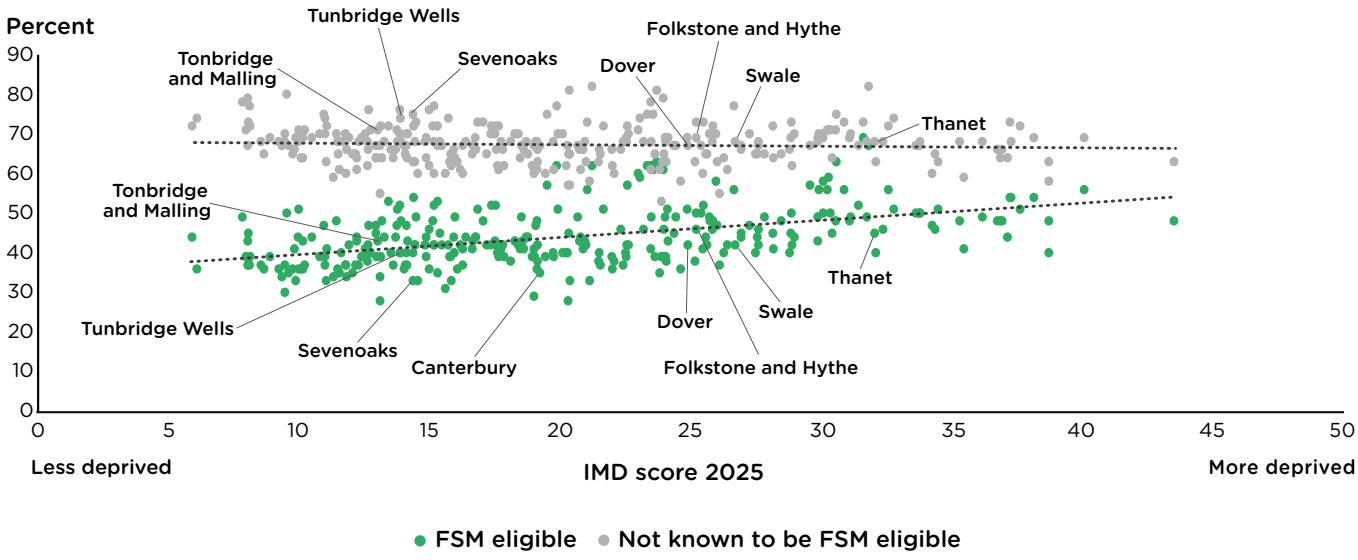
Source: *DfE, 2026*

3B. ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

A good level of educational attainment shapes access to economic opportunities later in life, and better educational outcomes often lead to higher-quality jobs, and higher income and earnings throughout life. The 2010 Marmot Review set outs a range of factors that impact educational outcomes, including socioeconomic features, parental support, housing conditions and experiences at school [1].

Figure 25 shows that, across England, a lower proportion of pupils eligible for FSM achieve the expected standards in reading, writing and maths than those not eligible for FSM. In less deprived councils and districts, the inequality in school achievements is wider, and in more deprived councils, children eligible for FSM do better than they do in less deprived areas. This trend is also observed in Kent.

Figure 25. Pupils achieving the expected standard in reading, writing, and maths at the end of key stage 2, by FSM eligibility and deprivation (IMD score 2025), English lower tier local authorities, 2024/25

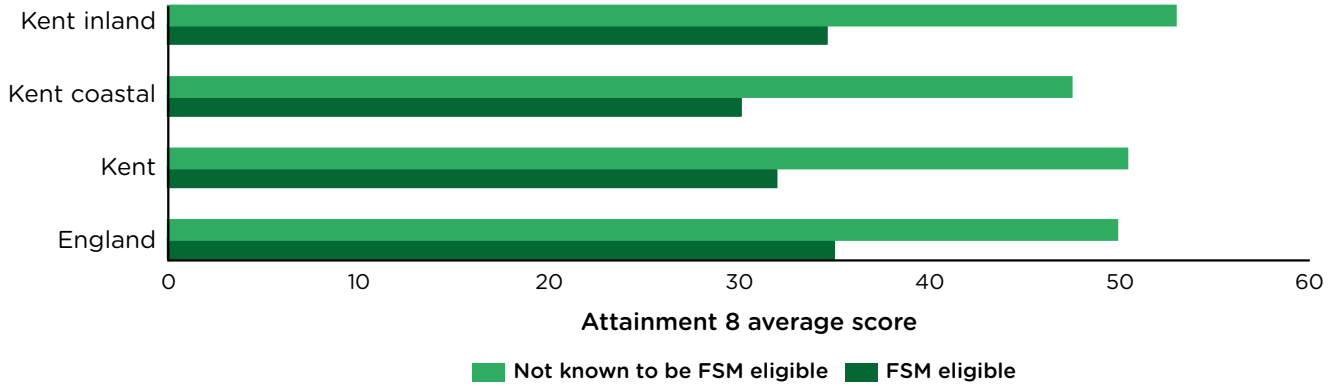


Source: *ONS and DfE, 2026*

The 'attainment 8' average score describes the achievement in 8 disciplines at the end of key stage 4, indicating the school performance of pupils who are preparing for their GCSEs (Figure 26). In Kent, as across England, pupils who are not eligible for FSM tend to perform better on the attainment 8 average than their counterparts across England. However, in Kent pupils eligible for FSM have a lower average score than pupils eligible for FSM in England.

Figure 26 also shows that pupils living in coastal districts perform less well than those living in Kent inland and nationally, whether they are eligible for FSM or not.

Figure 26. Attainment 8 average score by FSM status, Kent inland, Kent coastal, Kent and England, 2024/25



Source: *DfE, 2026*

Between July and September 2025, the Office for National Statistics (ONS) estimated that 12.7 percent of all 16–24-year-olds in the UK were NEET [29]. Evidence suggests the negative impacts of unemployment on health are more pronounced for young people, including an amplified risk of depression due to unemployment [30]. Furthermore, by the age of 21, those who have experienced being NEET are more likely to be unemployed, low-paid, have no training and suffer from poor health [31].

Figure 27 shows that the percentage of 16- to 17-year-olds who are NEET in Kent has been higher than in England between 2016-2024, except in 2017/2018. The proportion of young people who are NEET is also higher in the South East region and more research is needed to understand the drivers of these heightened levels.

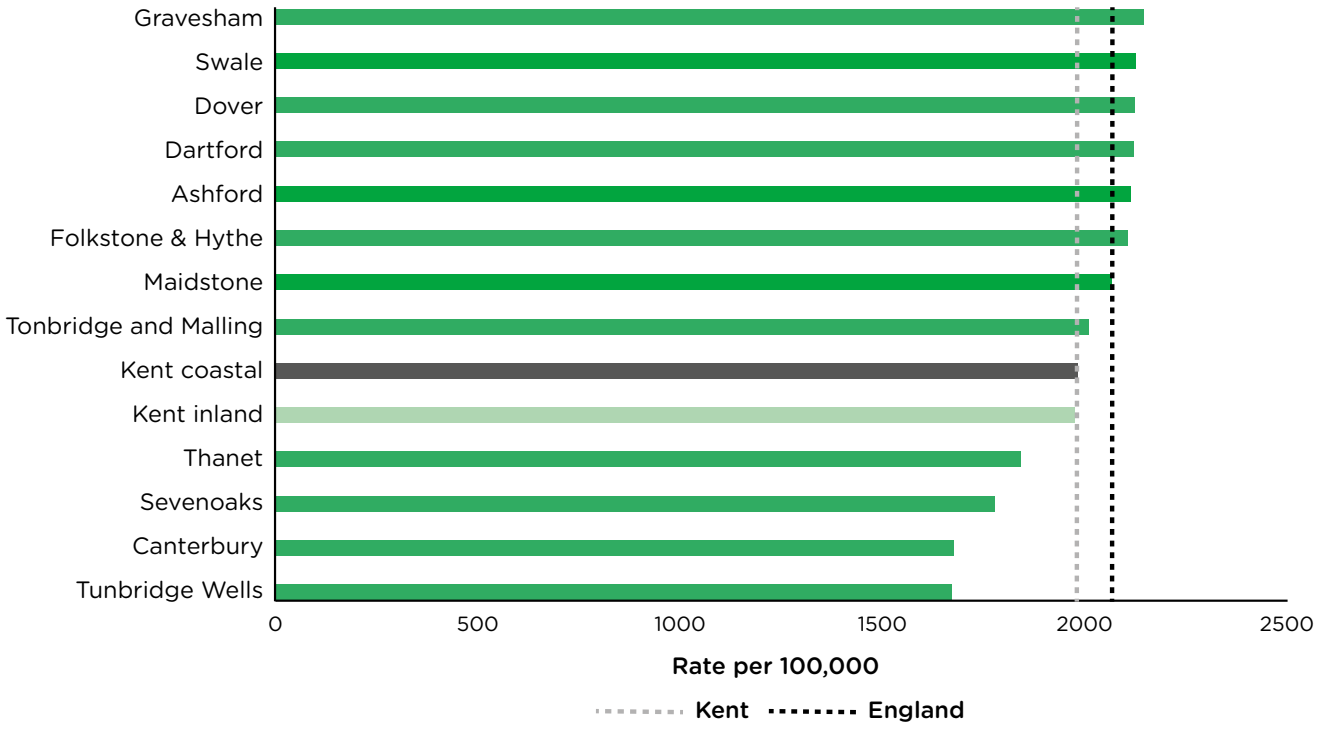
Figure 27. 16 to 17-years-old Not in Education, Employment or Training (NEET) or whose activity is not known, percent, Kent, South East, and England, 2016/17 to 2023/24

Source: *Fingertips, DfE data, 2026.*

Combining work and training, apprenticeships offer opportunities for young people from GCSE and A-level equivalent up to a degree. Skills programmes, such as apprenticeships, have demonstrated to be highly effective in improving people's health at all stages of life by increasing opportunities and access to good-quality, well-paid work [32]. Furthermore, apprenticeships are shown to improve an individual's confidence, facilitate social network building, and reduce social isolation [32].

The participation rate in apprenticeships is defined as 'the number of all age (16+) learners participating on an apprenticeship in England' by the Department for Education and is published for each academic year [33]. Figure 28 shows that the availability of apprenticeships in Kent (1,979 per 100,000) is slightly lower than in England (2,065 per 100,000). The level in coastal and inland districts is also similar to Kent overall. For districts, Tunbridge Wells and Canterbury have lower rates of participation (1,671 per 100,000 and 1,676 per 100,000 respectively), compared to Gravesham, Swale, Dover and Dartford, which all have higher rates than Kent and England. Swale and Dover are both coastal districts and more deprived than the other areas. The greater prevalence of apprenticeships in more deprived areas, shows positive steps to reduce NEET in more deprived areas, with the exception of Thanet.

Figure 28. Participation rate in apprenticeships per 100,000, Kent districts, Kent coastal and inland, Kent and England, 2024-2025



Source: *DfE, 2026*

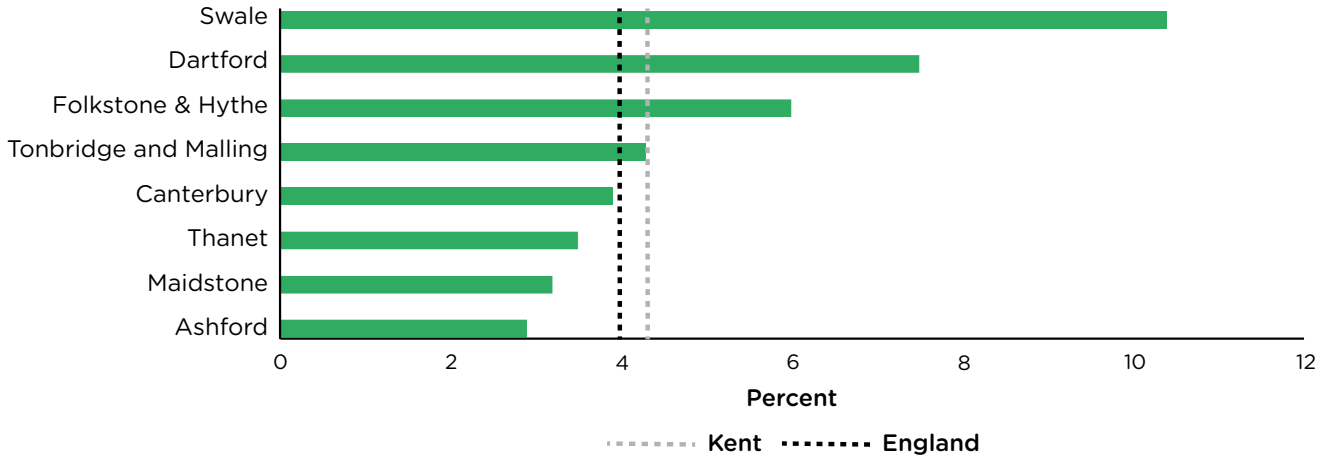
3C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Work and health have a bidirectional relationship: just as work is protective of health, poor health can limit one's ability to find and sustain work [34]. There is a robust evidence base affirming the damaging impacts of unemployment on health, and particularly long-term unemployment.

This applies too for psychological wellbeing, with some evidence suggesting that employment status is as, or more, important than other key determinants like income and education [35]. For instance, financial challenges caused by lack of work may reduce social integration and lower self-esteem. Being out of work is associated with increased likelihood of anxiety and depression, as well as behaviours harmful to health, such as smoking and alcohol consumption [1].

Figure 29 shows that, between 2024 and 2025, the rate of unemployment (defined by the rate of 'people without a job who have been actively seeking work within the last four weeks and are available to start work within the next two weeks') [36] was slightly higher in Kent (4.3 percent) than in England (4 percent), but also large differences between districts. The proportion of residents unemployed 2024-2025 was 10.4 percent in Swale, 7.5 in Dartford, both higher than in Ashford (2.9 percent) and Maidstone (3.2 percent), where the proportion is the lowest.

Figure 29. Unemployment rate, population aged 16 to 64 years old, percent, Kent districts*, Kent, England, April 2024-2025

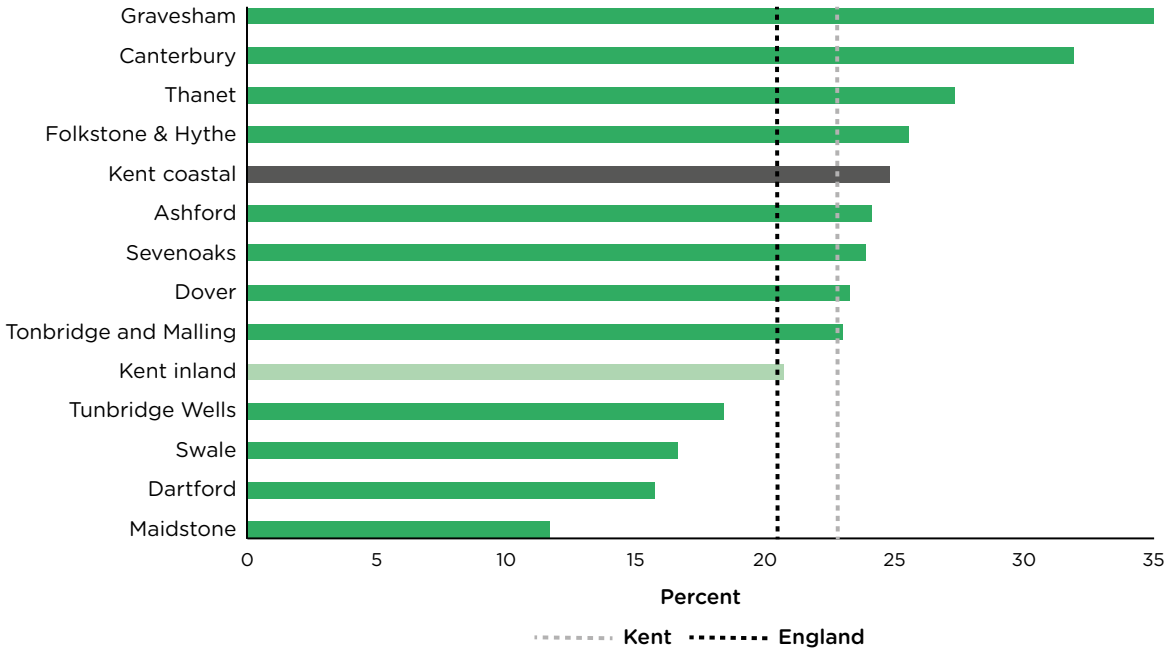


Source: *Nomis, 2026.*

Note: *data is missing for Dover, Gravesham, Sevenoaks and Tunbridge Wells.*

Figure 30 shows that the proportion of residents, aged 16- to 64-years-old who are economically inactive in Kent is higher than to England (22.8 and 20.5 percent, respectively), and there are marked differences between districts. 10.9 percent of residents are economically inactive in Dartford, the lowest rate of all districts, compared to Gravesham with nearly a third (35.9 percent) of residents of working age who are economically inactive and Canterbury with 31.9 percent. Overall, the percentage of residents between 16- to 64-years-old who are economically inactive is higher in coastal districts (24.8 percent) than in Kent inland districts (20.7 percent).

Figure 30. Economically inactive residents, 16 to 64 years old, percent, Kent districts, Kent coastal and inland, Kent, and England, 2025



Source: *Nomis, Annual Population Survey and ONS 2026*

Note: *The data comes from the Annual Population Survey, a representative sample of the population.*

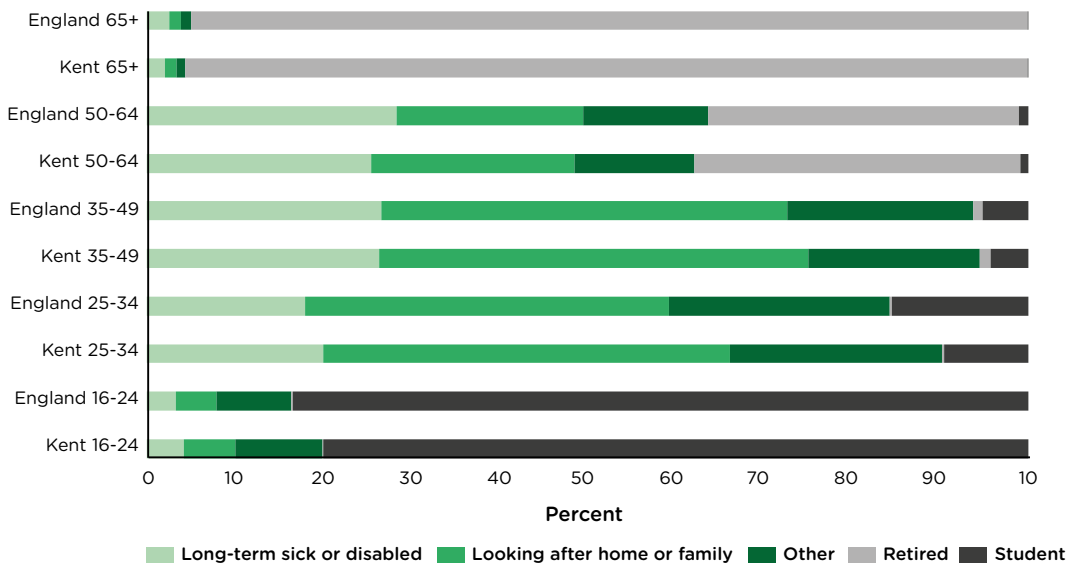
Figure 31 compares the reasons for economic inactivity, among economically inactive residents, by age groups in Kent and England.

Among people aged 16- to 24-years-old, the proportion of people who are economically inactive due to being a student is lower in Kent (80 percent) than in England (83.5 percent).

In Kent, 46.1 percent of economically inactive residents from 25- to 34-years-old are looking after home or family members, a higher proportion than in England (41.3 percent). The proportion is also higher for residents aged 35- to 49-years-old.

The residents who are economically inactive because of a long-term sickness or are disabled, account for 20 percent economically inactive residents from 25- to 34-years-old in Kent, the lowest, compared to 17.9 percent in England on average.

Figure 31. Reasons for economic inactivity, by age groups, Kent and England, 2021



Source: *Nomis, Census 2021, 2026*

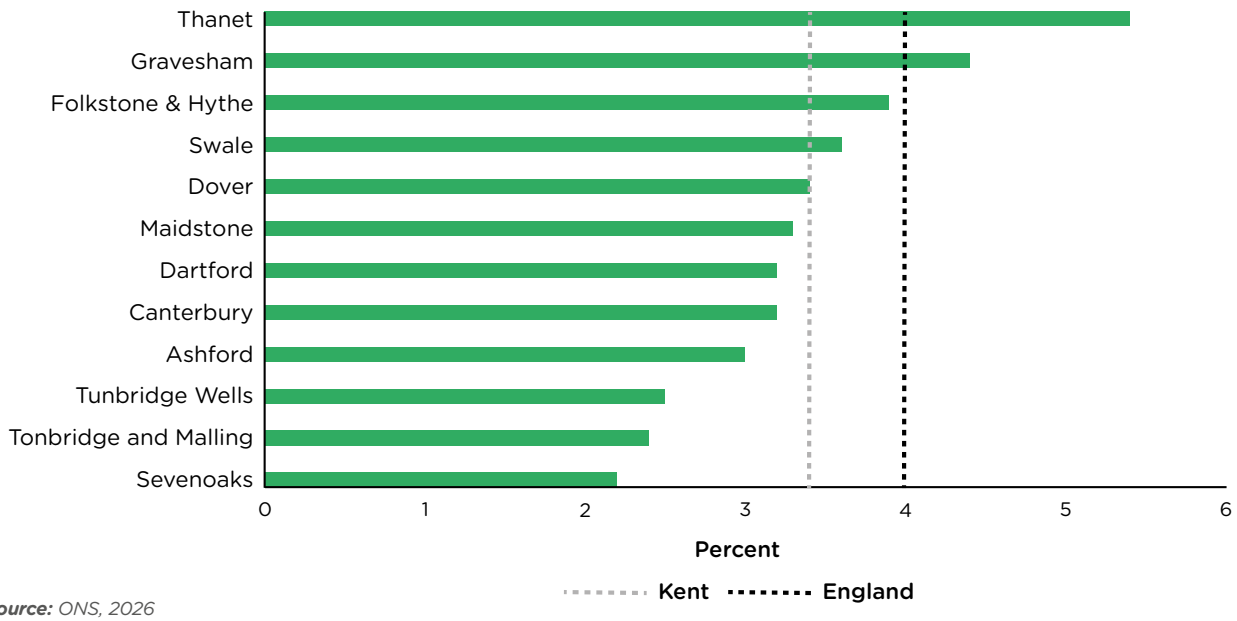
3D. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

Being on low income and in receipt of benefits is associated with poor physical and mental health and often experiencing poor quality living conditions. The central benefits in the English system are job seekers allowance and universal credit. The job seeker allowance is a contribution for people aged 18 or older who are unemployed or working fewer than 16 hours a week and are actively seeking employment. The weekly allocations are low, up to £72.90 for 18- to 24-year-olds and up to £92.05 for people over 25-years-old. Universal Credit is a broader benefit which is means-tested and designed to help with living costs.

However, evidence shows that income from sources of state benefit is insufficient to support a healthy lifestyle, particularly with the rising cost of living. Research from the Joseph Rowntree Foundation clearly states that recipients of benefits face elevated levels of hardship and are disproportionately at risk of food insecurity [37].

As shown in Figure 32, the percentage of people living in Kent and claiming job seeker allowance and/or Universal Credit is higher in coastal districts, than in inland districts, indicating important economic inequalities. Rates are particularly high in Thanet (5.4 percent), Gravesham (4.4 percent) and Folkestone and Hythe (3.9 percent), but overall, less prevalent in Kent (3.4 percent) than in England. In the districts of Sevenoaks, and Tonbridge and Malling (both inland districts), 2.2 percent and 2.4 percent of residents, respectively, claim job seeker allowance and/or universal credit, below Kent and England's average. Future analysis will explore this at a more granular level.

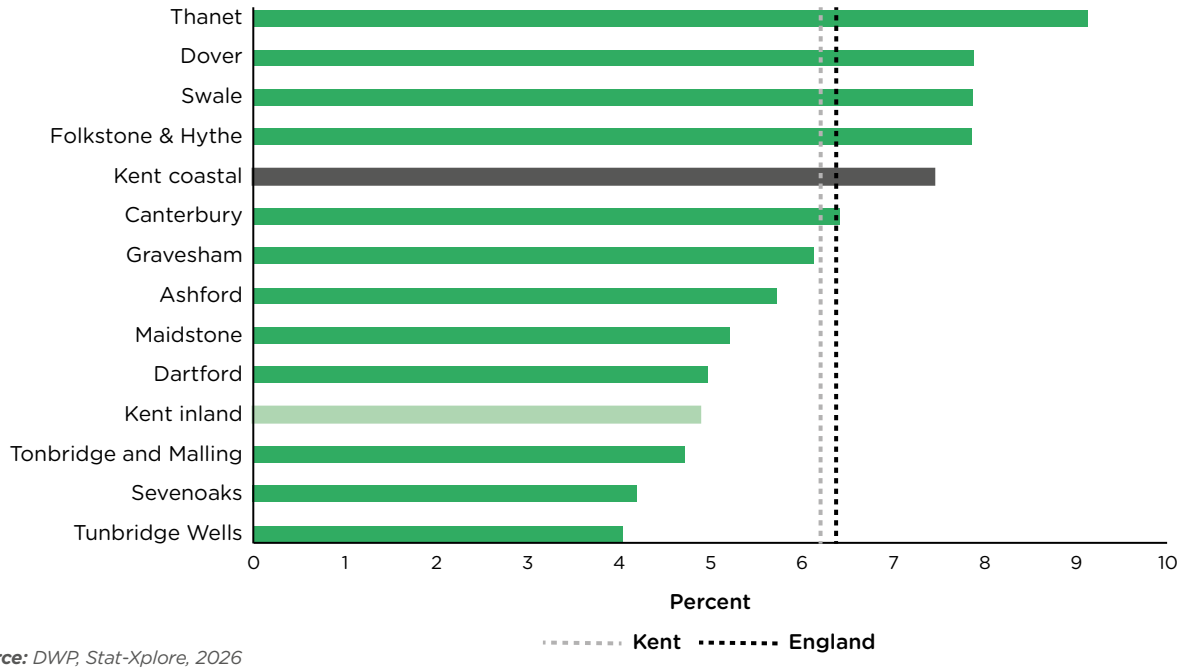
Figure 32. Job seeker allowance and/or Universal Credit claimants, percent, Kent districts, Kent, and England, November 2025



Source: *ONS, 2026*

Personal Independence Payments (PIP) support people financially when they have 'a long-term physical or mental health condition or disability and a difficulty doing certain everyday tasks or getting around because of their condition' [38]. The percentage of people entitled to PIP in September 2025 in Kent (6.2 percent) is close to the England average (6.4 percent). However, the percentage by districts varies widely from 4 percent in Tunbridge Wells and 4.2 percent in Sevenoaks, to 9.1 percent in Thanet. The rate of PIP cases is larger in coastal (7.4 percent) than in inland districts (4.9 percent) indicating higher rates of limiting disabilities in coastal areas. The most deprived districts are also those where the rate of residents entitled to PIP is the highest. Further analysis will look at this figure by age, as the rate of PIP entitlements increases after 55.

Figure 33. Independence Payment (PIP) Cases with Entitlement, percent, Kent districts, Kent inland and coastal districts, Kent, and England September, 2025

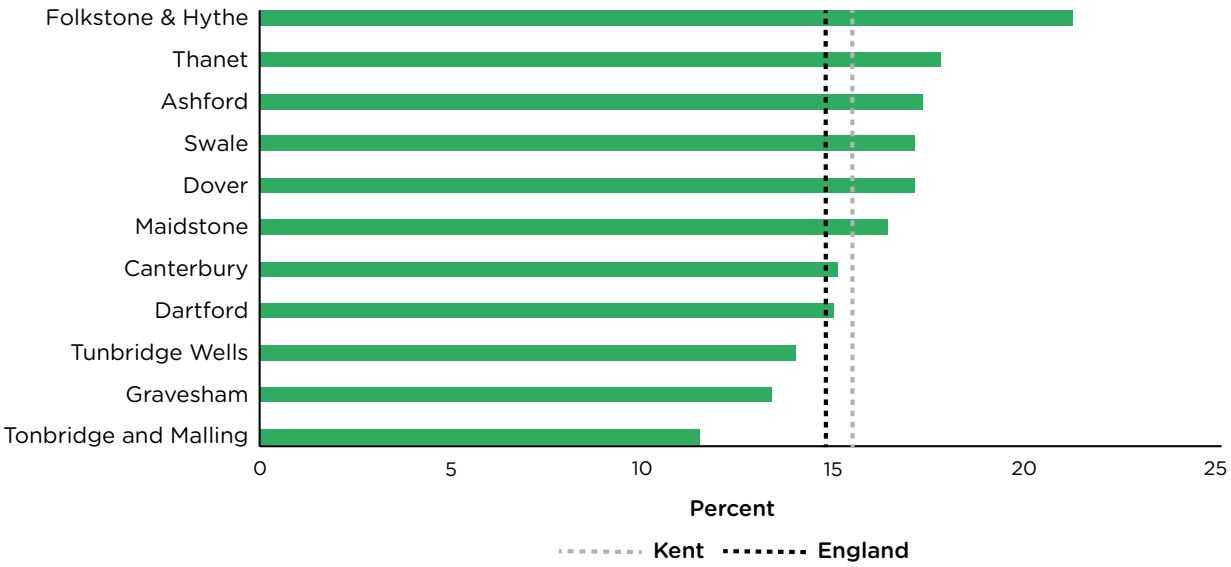


Source: *DWP, Stat-Xplore, 2026*

The living wage is designed to provide lower-paid employees with sufficient income to cover their cost of living [39]. The negative health effects driven by insufficient income can be caused by material factors, such as an inability to afford goods necessary for a healthy life, and/or psychological factors, such as the stress of being debt. Adoption of the living wage by organisations has been shown to improve employees' psychological health, as well as increasing life expectancy [39]. In 2025, the Living Wage Foundation estimates the living wage at a minimum of £14.80 per hour in London and £13.45 per hour across the rest of the UK [40].

As shown in Figure 34, the percent of employees earning below the living wage is higher in Kent (15.4 percent) than in England (14.7 percent), but there are wide differences between coastal and inland areas. Specifically, the number of employees earning below the living wage is higher in five of the six coastal districts, such as Folkestone and Hythe (21.1 percent) and Thanet (17.7 percent), both relatively more deprived areas than Kent and England's averages.

Figure 34. Employees earning below the living wage, percent, Kent districts, Kent, and England, 2025



Source: *ONS, 2026.*

Note: estimates for Sevenoaks are considered unreliable, therefore Sevenoaks is not included on this chart.

3E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

FUEL POVERTY

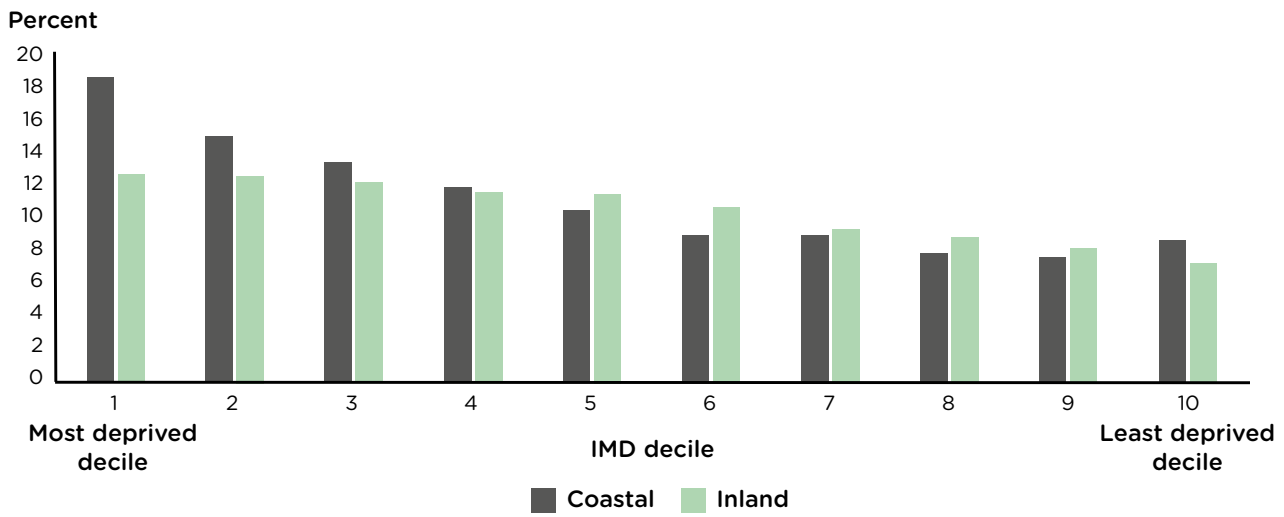
'Fuel poverty' occurs when a household cannot afford to adequately heat their home or meet basic energy requirements, and is driven by three elements: household income, the affordability of energy and the energy efficiency of a home [41]. A household that is in fuel poverty is at risk of living in a cold home, which can have both physical and mental health consequences, especially for children, older people or those living with pre-existing health conditions [42]. This includes a doubling in risk of adults developing new mental health conditions and increasing risk of physical conditions such as high blood pressure and respiratory problems [43].

The proportion of households experiencing fuel poverty in Kent coastal and inland areas has been constructed at the LSOA level and is shown in Figure 35. The rate of fuel poverty is, unsurprisingly, highly correlated with deprivation and is twice the rate in lower deciles than in higher deciles.

In the three lowest deciles, the proportion of households experiencing fuel poverty is noticeably higher in Kent coastal areas than in inland areas. For instance, the most deprived decile of the coastal population has 18.6 percent living in fuel poverty compared to 12.7 percent inland.

This demonstrates that when controlling for deprivation and 'isolating the coastal effect', the residents of coastal areas experience much higher fuel poverty than in inland areas. This may be due to deeper deprivation in coastal areas.

Figure 35. Households experiencing fuel poverty, by IMD deciles, percent, Kent coastal and inland Lower-layer Super Output Areas (LSOAs), 2023



Source: *Fingertips, OHID, 2026*

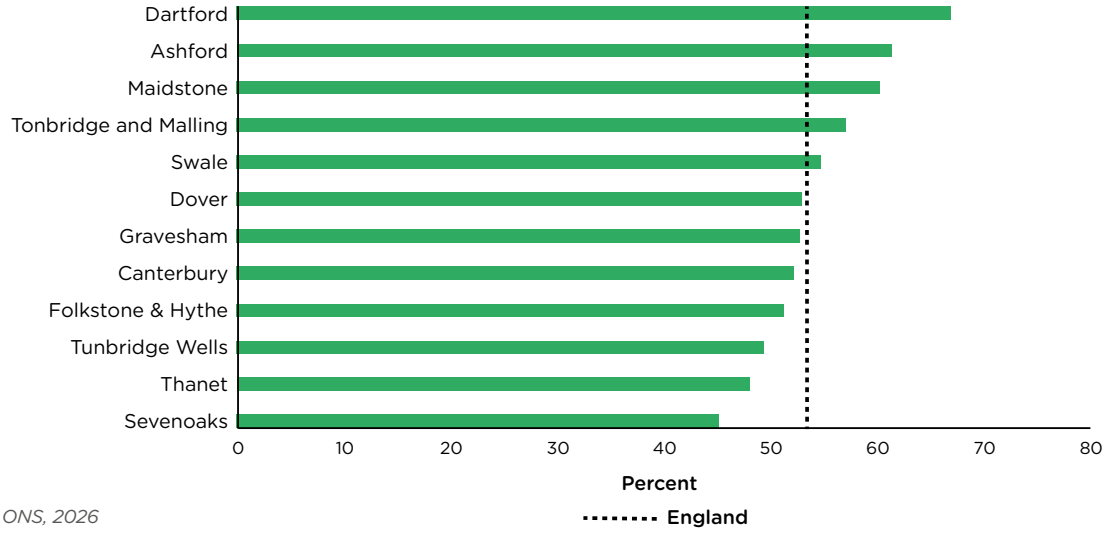
An Energy Performance Certificate (EPC) measures a property's energy efficiency through bandings of letters A through to G, where A is the highest energy efficiency and G is the lowest. On a national level, England's housing stock is among the least energy efficient in Europe.

An EPC of D to G indicates lower levels of insulation and higher fuel costs. Meanwhile, ratings A, B and C are considered efficient, very efficient or above average energy efficiency, respectively, for a home and therefore considered sufficiently healthy living environments.

The proportion of dwellings with an EPC rating above C by district can be seen in Figure 36. Households living in Dartford have the highest rate of dwellings with an EPC rating of C and above, followed by Ashford. The lowest proportion is in Sevenoaks; this is likely related to older, detached housing in the area.

There does not appear to be a clear association between inland and coastal parts of Kent and EPC ratings. However, it is necessary to analyse this at a smaller geography to recognise the likely intra-district variation. This will feature in the next output of the coastal indicators work.

Figure 36. Dwellings with an EPC rating C and above, percent, Kent districts and England, March 2015 to March 2025



Source: *ONS, 2026*

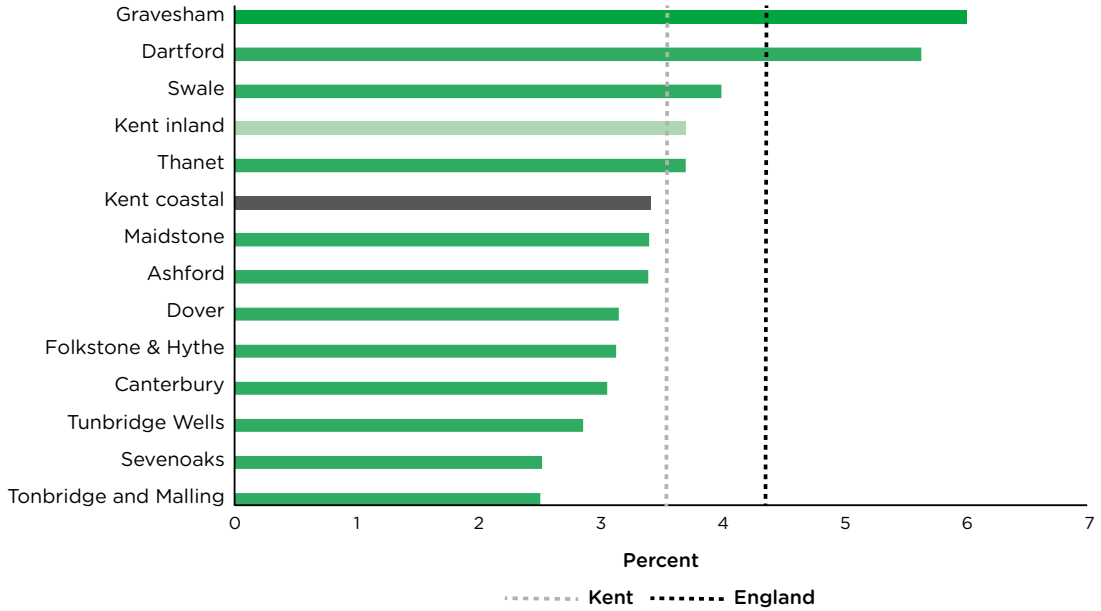
OVERCROWDING

Overcrowding is defined by the ONS using the standard housing occupancy, which compares the number of bedrooms a household requires with the number of bedrooms available [44]. Unaffordable housing leads to overcrowding and homelessness for people across the UK [45]. Recent IHE work with Northumberland found that there is a lack of housing in rural and coastal tourist hotspots due to an increase in the number of short lets available for tourists. Based on Figure 37, estimating the percent of households having an occupancy rating of fewer bedrooms than required, by districts, this pattern is not observed as clearly in Kent, as there is little difference between inland and coastal (tourist) areas. However, it may be contributing to higher rates of overcrowding in Dartford, a relatively affluent coastal area. Further analysis on seasonal variations in housing use is needed to explore the impact of tourism on overcrowding in Kent more comprehensively.

Overall, the estimated rate of overcrowding is lower in Kent (3.6 percent) than in England (4.4 percent), with only small differences between Kent inland and Kent coastal districts.

Within districts, the rate of overcrowding is highest in Gravesham (6 percent), an inland district where the deprivation is higher than in Kent and in England, and Dartford (5.6 percent) an inland district (more affluent than the average in Kent), both more than 2 percentage points over the Kent average.

Figure 37. Occupancy rating (bedrooms) of -1 or less, Kent districts, Kent coastal and inland, England, Census, 2021



Source: *Census 2021, ONS*

** Overcrowding is defined as an occupancy rating of -1 or less. This implies that a household's accommodation has fewer bedrooms than required*

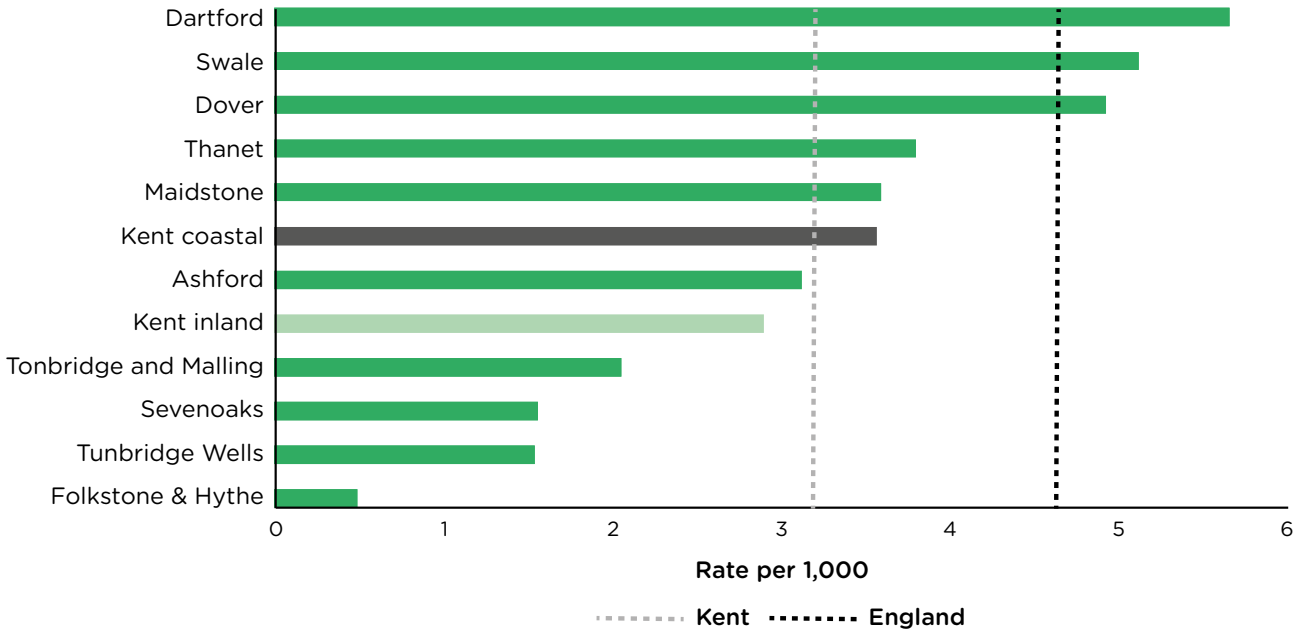
HOUSING INSECURITY

Housing insecurity – an inability to access and maintain safe and stable housing – is associated with poor health [46]. Families placed in temporary accommodation who took part in a study by Shelter reported that their health suffered in numerous ways, including the development of mental health problems and worse physical health [47]. Research has also demonstrated negative impacts on school attainment including missing days of school, and the mental and physical health of children [48].

A proxy measure for housing insecurity is exploring the rate of households in temporary accommodation. This is measured by the rate of 'households living in temporary accommodation secured by a local housing authority under their statutory homelessness functions' per 1,000 households [49]. The definition of the 'temporary' duration is not standard and can be for 12 months or more [49]. For these reasons, this indicator has some limitations.

Figure 38 shows that the rate of residents staying in temporary accommodation is lower in Kent (3.2 per 1,000) than in England (4.6 per 1,000). Among Kent's districts, the lowest is in Folkestone and Hythe (0.5 per 1,000) and the highest in Dartford (5.6 per 1,000), Swale (5.1 per 1,000) and Dover (4.9 per 1,000) all of which have higher rates than average in England. Kent coastal areas have higher rates of households living in temporary accommodation than inland areas in Kent.

Figure 38. Households in temporary accommodation, rate per 1,000, Kent districts, Kent coastal and inland, Kent, and England, 2023-2024



Source: *Fingertips, OHID based on MHCLG data, 2026*

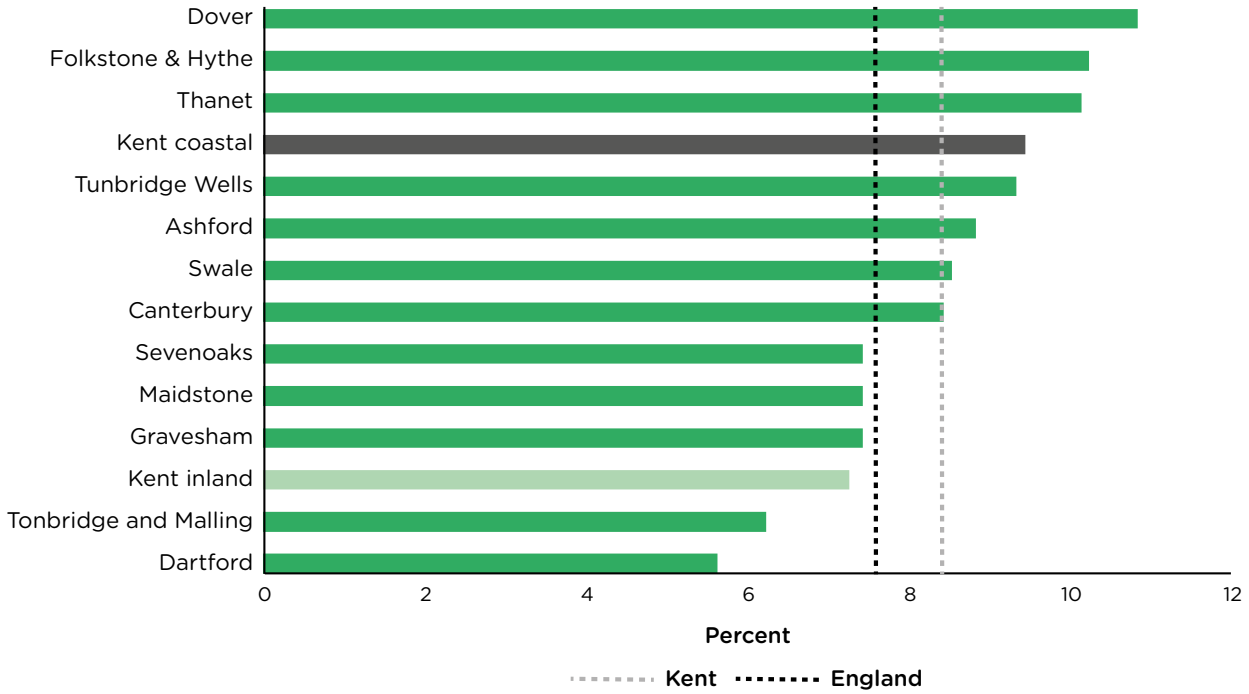
Note: *missing data for Canterbury and Gravesham*

HOUSING QUALITY

The Housing Health and Safety Rating System assesses 29 categories of hazards in homes grouped into the following categories: physiological requirements (including damp, mould, excess heat, excess cold, and pollutants), psychological requirements (including security and noise), protection against infection, and protection against accidents (including falls and electrical hazards). A home classified with a category 1 hazard poses serious threats to the health and safety of its occupants [50]. Recent analysis about reducing inequalities in healthy life expectancy in Northumberland established the importance of well-insulated housing.

Figure 39 shows that the percentage of homes with category 1 hazards in Kent is higher in coastal districts (9.4 percent), than in inland districts (7.2 percent). The figures in Kent are higher to the England average. Furthermore, the differences between districts are quite marked, with higher rates of homes with category 1 hazards in Dover, Folkestone and Hythe and Thanet, the most deprived districts, than in Dartford and Tonbridge and Malling, less deprived.

Figure 39. Homes with Category 1 Hazards (all households), Kent districts, Kent coastal and inland districts, Kent, and England, 2023



Source: *English Housing Survey, 2023*

CHAPTER 4

RECOMMENDATIONS FOR ADDRESSING HEALTH INEQUITY IN KENT

Kent has a wealth of opportunities and promising work taking place to support health and strengthen the social determinants of health across the area. However, as seen above, the average measures in Kent often disguise steep health, economic, and social inequities. This is evident when moving from Kent County level data to district level, then again when exploring data at the MSOA and LSOA level. The assessment begun in this report also highlights significant differences in many important areas for health and the social determinants of health between coastal and non-coastal areas in Kent.

Based on this analysis, the IHE has developed recommendations to further develop programmes and approaches which are based on achieving greater health equity and reducing inequalities in key social determinants of health. As the initial programme in Kent is focused on the coastal regions, the below recommendations are chosen based on Marmot priorities where there is evidence of inequalities between coastal and inland areas and which align with the Marmot principle of creating good work and fair employment for all, given this determinant was identified as a priority for the programme. Inequalities in skills and employment outcomes in Kent, as in England, are shaped by inequalities in early child development and in educational attainment which persist throughout life and influence opportunities for quality employment and development of skills. Therefore, it is important to recognise that, to improve employment and skills in Kent, action must be taken on reducing inequalities across the life course, during pregnancy, infancy, through early years, childhood and into adulthood.

However, while coastal communities in Kent experience particularly poor outcomes, there remain many inequalities and challenges for residents living in every area of Kent. This is evidenced by the fact that even in the least deprived areas, more than 10 percent of children are living in poverty and need additional support to reach their potential. As the Kent Marmot Coastal Region approach evolves, action will need to move beyond the dichotomy of 'inland versus coastal'. Full and sustainable embedding of health equity through collaborations and partnerships, and in resource allocations, decision-making and the design and delivery of support and services, is needed. By beginning work focusing on the coast, we hope to generate insights and pioneer ways of working that will help reduce inequalities across the whole of Kent.

The below recommendations are framed by the Marmot approach outlined in Figure 4: strengthen action on the Marmot 8 principles, develop cultures and systems for health equity, and embed transformational processes which support and operationalise action sustainably.

These now require input and refinement from organisations and sectors across Kent, and the development of actions and implementation of programmes to deliver greater health equity.

TAKE ACTION ON THE MARMOT PRINCIPLES IN KENT

REDUCE INEQUALITIES IN YOUNG PEOPLE'S DEVELOPMENT AND EDUCATIONAL ATTAINMENT

- Embed programmes that build resilience and support young people's and whole family mental health through new neighbourhood health approaches and Best Start in Life Family Hubs, with additional resources in more deprived areas.
- Develop a wellbeing survey across all schools in Kent for pupils.
- Provide opportunities for students to be school-based champions for wellbeing to ensure the voice of students informs school programmes and policies.
- Work in partnership with businesses and other employers to provide skills development and training opportunities for young people aligned with local need, beginning in year 6. In particular, prioritise those most at risk of NEET and economic inactivity.
- Require schools in Kent to share and implement best practice around raising the attainment of children eligible for FSM with the aim to flatten the gradient and raise attainment to the level of England's average for all pupils.
- Develop careers services within community hubs to link with local employers to reduce the proportion of young people who are NEET.

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL, WITH A FOCUS ON SKILLS

- Anchor institutions and local economic partnerships to work closely with schools and colleges in coastal areas and areas with higher levels of deprivation to provide apprentices, job training, and employment shadowing for young people, with opportunity for longer-term employment.
- Develop a Kent 'good work' charter which sets out features such as a minimum income, maximum working hours, opportunities for development, provision of in-work benefits, and encourage public and private employers to sign up.
- Encourage employers and small businesses to partner and collaborate to support adult education and upskilling.
- Increase funding for lifelong learning and adult education more in areas of higher deprivation and target provision in areas with the highest levels of benefit claimants.

ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

- Collect and publish data on local employers paying the Real Living Wage, and encourage those who are not, to adopt it as a step to preventing in-work poverty.
- Work with local community, anchor institutions and employers to reduce levels of debt by increasing financial management advice in schools and workplaces.
- Integrate employment and debt advice into neighbourhood health, family hubs and other community services, learning from other places, such as Coventry's Job Shop, working across organisational and geographical boundaries.

ENSURE ALL HOMES IN KENT ARE OF DECENT STANDARD

- Increase insulation in households with low incomes to reduce fuel poverty.
- Create a health and housing referral service that people living in or at risk of fuel poverty can self-refer to. This should provide tailored, personal advice and be available as both a face-to-face and telephone service. This should then link with health and social care and voluntary sector organisations so that residents receive onward referral to services as appropriate.
- Work with both residents and landlords to identify the best methods to communicate risks of damp and mould and manage internal air quality, in line with the upcoming legislation protecting renters' rights.
- Developers to work in collaboration with local communities to identify the type of housing and places appropriate for local residents in Kent.

STRENGTHEN CULTURES AND SYSTEMS FOR HEALTH EQUITY IN KENT

BUILD A COLLECTIVE UNDERSTANDING OF THE ISSUES THAT DIFFERENTIALLY IMPACT COASTAL AND INLAND KENT

- Conduct extensive engagement with communities to build a qualitative understanding that reflects the complexities different residents experience, across both coastal and inland Kent, building upon previous resident engagement efforts to reduce consultation fatigue.

STRENGTHEN THE ROLE OF BUSINESSES AND EMPLOYERS IN IMPROVING HEALTH

- Ensure businesses are embracing principles of good quality employment including secure employment, decent pay and conditions, and adhering to the 'good work' charter.
- Employers to create innovative approaches to ensuring there are incentives to work, for example, making reasonable adjustments and providing flexible work.
- Employers should work with their entire workforce to support good physical and mental health including provision of advice and support for social determinants of health such as financial management, housing advice and referrals, and healthy living.
- Businesses should assess health of their employees as a core consideration when making investment decisions and integrate into environmental, social and governance initiatives.

PUBLIC SECTOR AND OTHER LOCAL ANCHOR INSTITUTIONS IN KENT TO LEAD BY EXAMPLE

- All public sector employers to develop as anchor institutions, with increasing development of business anchors.
- Anchor institutions to lead an employer movement to increase knowledge and understanding about the importance of good work to health and inequalities.
- Anchor institutions to offer work experiences for young people, support young people to be leaders, and consider developing a local volunteering mentor programme.
- Require public sector employers to further their contribution as anchor organisations to meet their core public service purpose through their employment practices.
- Increase the social value requirements in public sector contracting processes.
- Develop schools as anchor organisations and community hubs.

TRANSFORMATIONAL PROCESSES

TAKE AN ASSET-BASED APPROACH BY BUILDING ON WHAT ALREADY EXISTS

- Map the services, interventions, and programmes that already exist across Kent to identify where the gaps in provision for services that support the social determinants of health lie and connecting up the promising work already happening across Kent.
- Build a local network of organisations prioritising health equity and create a shared space to share best practice (such as through the Health Equity Network).
- Activate, value and collaborate with VCFSE organisations.

EMBED PROPORTIONATE UNIVERSALISM IN POLICY AND PRACTICE IN KENT

- Ensure resources, services, and other assets aiming to improve social determinants of health are rolled out in proportion to need through a proportionate universalist approach.
- Ensure that skills building and employment services are universally available but with support provided in a way which is proportionate to distance from the job market.

CREATE A LONG-TERM, HEADLINE AMBITION FOR HEALTH EQUITY IN KENT, OWNED BY STAKEHOLDERS

- Set a headline ambition and secondary targets to ensure that progress on health equity is widely owned and acted on across the system, such as a reduction in the life expectancy between the richest and poorest residents in Kent.

MONITOR PROGRESS TOWARDS AMBITIONS AND TARGETS

- Continue and extend the quantitative analysis outlined in this report, leading to the development of Kent Coastal Indicators to understand and monitor changes in inequalities between coastal and inland areas.

NEXT STEPS: LAUNCH OF THE CONSULTATION PROCESS AND FURTHER DATA ANALYSIS

These recommendations are purposely pitched at a high-level as this report publication triggers the beginning of a stakeholder consultation with a range of sectors and organisations across Kent. The process of consultation will allow for sense checking of the relevance and practicality of these recommendations and will assist in the identification of gaps in provision by local stakeholders. The consultation will lead to development of a short briefing and action plan with next steps from system partners outlined later in 2026.

While this data-led report begins to analyse differences in social determinants of health between inland and coastal populations, the IHE will publish a data pack later in 2026 that further disaggregates some indicators at smaller geographical levels. This will further unpick whether coastal inequalities are a proxy of deprivation, poor access, or an independent effect of being coastal that is unique to towns with proximity to the sea and estuaries.

ANNEX

ANNEX A: MEMBERSHIP OF THE ADVISORY BOARD

Professor Sir Michael Marmot (Chair) — Director of the Institute of Health Equity, UCL

Dr Anjan Ghosh — Director of Public Health, Kent County Council

Claudia Sykes — VCSE Representative

Colin Carmichael — Chief Executive, Thanet District Council – supporting

Christine McInnes — Corporate Director of Education at Kent County Council

Dan Shelley — Skills and further education

Dr Ellen Schwartz — Deputy Director of Public Health, Kent County Council

Dr Jessica Allen — Deputy Director of the Institute of Health Equity, UCL

Larissa Reed — Chief Executive, Swale Borough Council (representing six boroughs)

Lauren Blum — Senior Researcher, Institute of Health Equity, UCL

Nick Fenton — Business/Economy Representative

Prathiba Ramsingh — DWP South East Group Director

Rachel Hewett — Director of Systems Strategy, ICB

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Audrey Beadle – Public health specialist

Becky Waller - DWP

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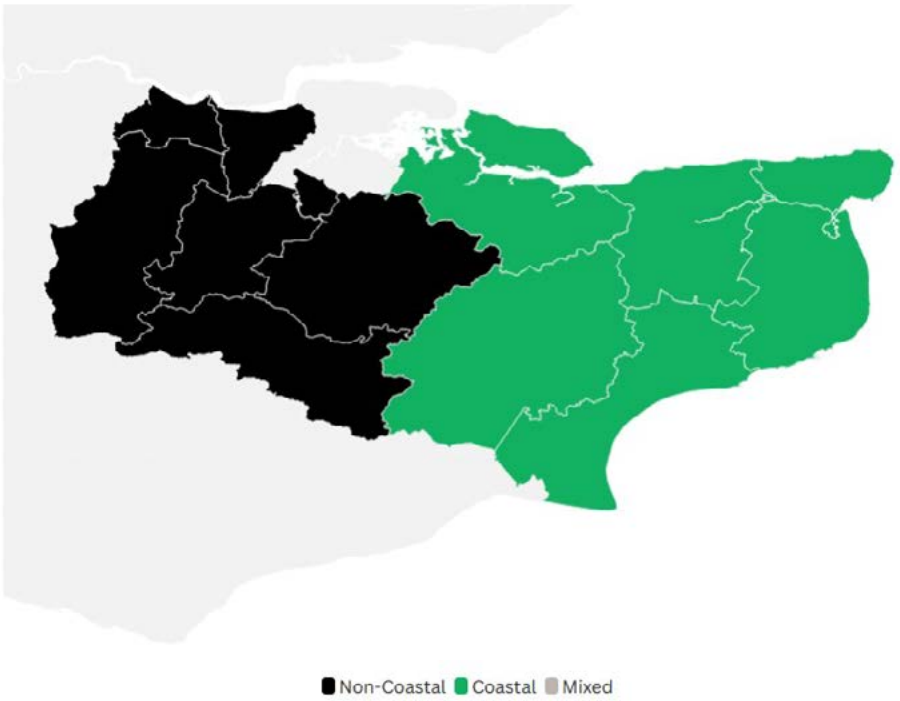
Tracey Kerly – Chief Executive – Ashford Borough Council

William Bacon – Project Support Officer, EKHCP

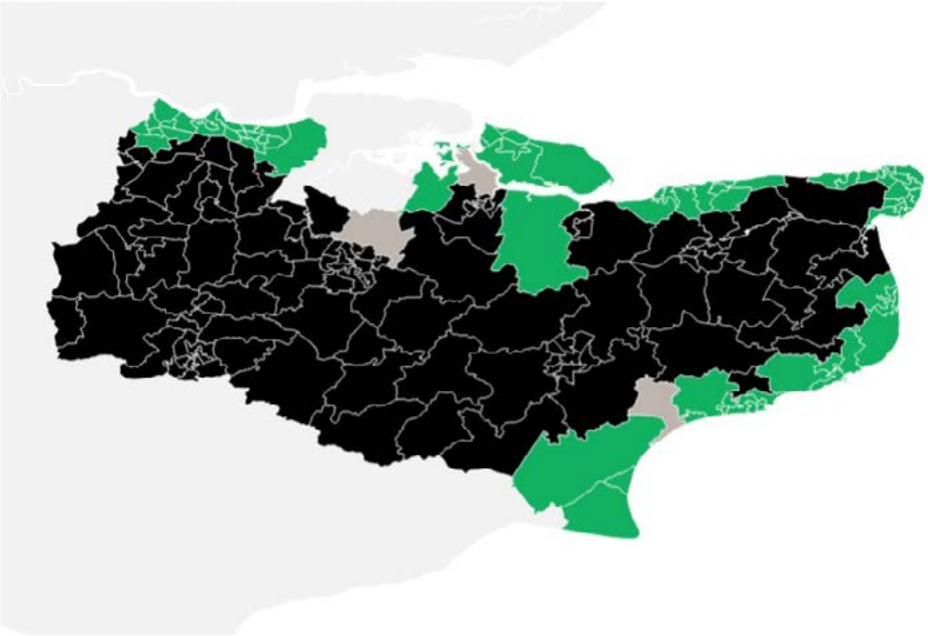
ANNEX C: COASTAL CLASSIFICATION AND MAPS

	Inland	Coastal	Mixed	Total
Number of LSOAs	567	371	-	938
Population count 2024	997,466	641,563	-	1,639,029
Number of MSOAs	107	74	2	183
Population count	977,866	639,357	21,806	1,639,029
Number of districts	6	6	-	12
Population count	872,361	766,668	-	1,639,029

MAP OF KENT, COASTAL CLASSIFICATION BY DISTRICT



MAP OF KENT, COASTAL CLASSIFICATION BY MSOAS



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